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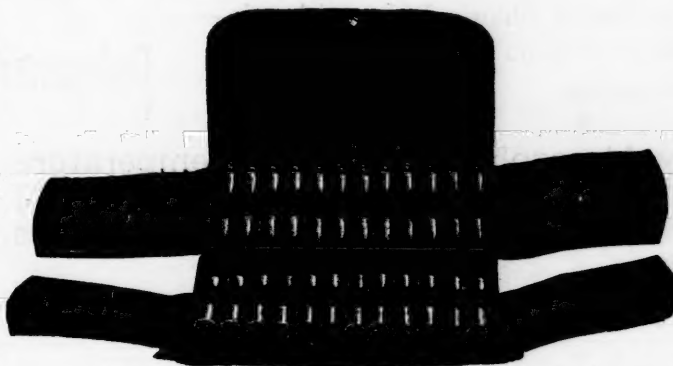
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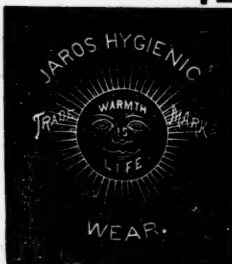
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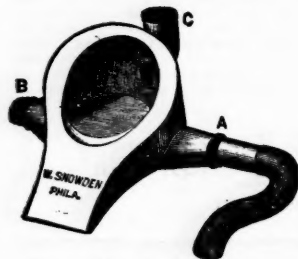
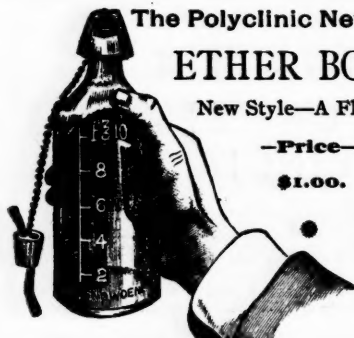
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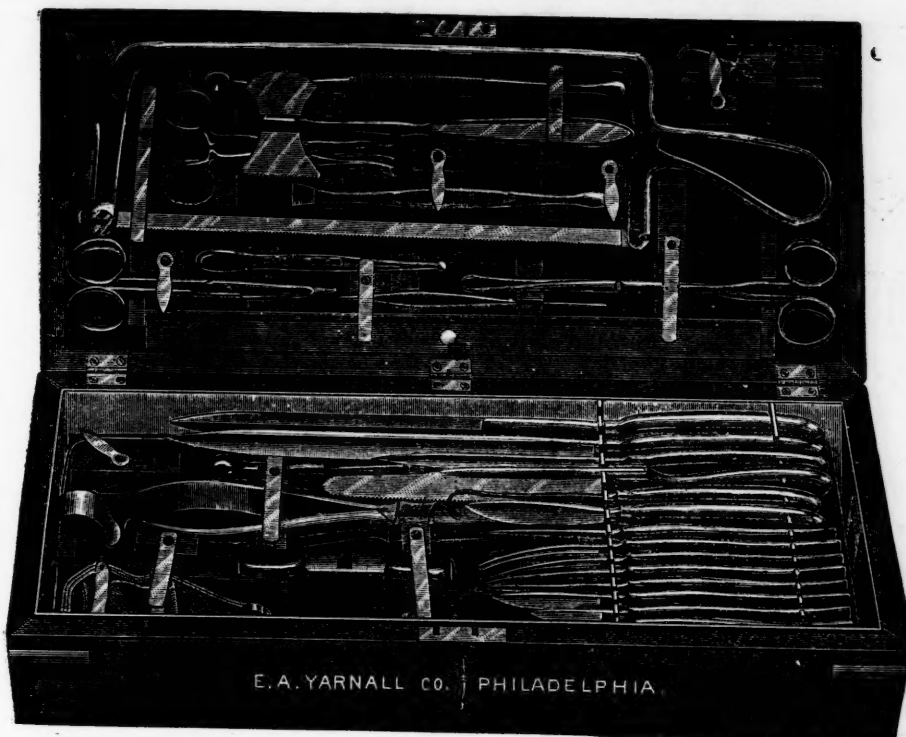


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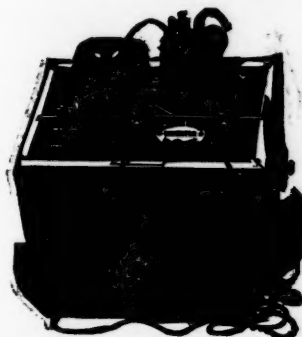
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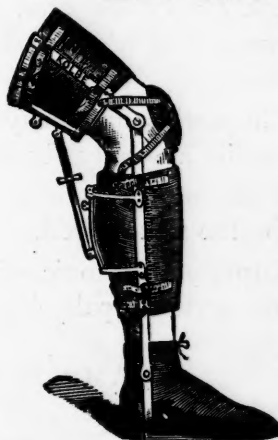
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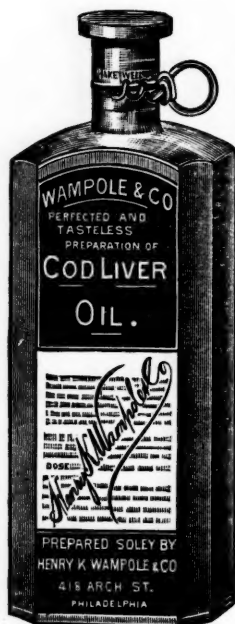
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Vol. XXIII, No. 24.

NEW YORK AND PHILADELPHIA, DECEMBER 12, 1891.

Whole No. 692.

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CLINICAL CONTRIBUTIONS TO BRAIN SURGERY¹

By JOHN B. ROBERTS, M.D.,

Professor of Anatomy and Surgery in the Philadelphia Polyclinic; Professor of Surgery in the Woman's Medical College of Pennsylvania.

IN 1885² I took strong grounds in favor of more active surgical interference in injuries and diseases of the cranium and brain. At that time the views advocated by me were looked upon as being too radical, and were quite vigorously opposed by many prominent surgeons of this country. Since that date there has been developed an unprecedented activity in the operative treatment of cranial and intra-cranial lesions, which, even in my opinion, has been too extreme. It is, perhaps, not difficult to understand this unscientific and unreasonable adoption of what might be called a surgical fashion. It is to be regretted that the enthusiasm created by success impels some men to interfere surgically in nearly all cases that come into their hands, without a judicious study of each particular patient. That unrestrained mania for operating which has made abdominal surgery almost a by-word has, it seems to me, entered into the domain of cerebral surgery. It is just as much a part of scientific surgery to abstain from operating unnecessarily, as it is to combat vigorously the unreasonable conservatism of those who will not see the force of anatomical, surgical, and statistical evidence. Fortunately for the patients, a healthy reaction is at last taking place, and surgeons

are not now removing brain centers and tunnelling the brain in search of abscesses and tumors in quite as enthusiastic a manner as they were a couple of years ago. That such lesions should be promptly attacked surgically is unquestioned; but this should be done only after a thorough survey of the conditions, and a judicial estimate of the gain that will possibly arise. The experimental character of many operations upon the brain in recent years has been almost as patent as in vivisectional operations done with an avowed experimental purpose. Death on the operating table and unsuccessful operations have at length begun to stay the hands of these over-enthusiastic surgeons; and there is now ground for hope that cerebral surgery will, ere long, become less reckless.

My personal opinions are very much what they were in 1885; indeed, the advances in diagnosis and the improvement in operative methods have made me even more sure of the correctness of the conclusions then advanced. I cannot, however, bring myself to approve of the reckless way in which human life is often threatened by operations which hold out scarcely a ray of hope to the helpless patient. The rapidity of healing in aseptic wounds, and the tolerance of the brain under operative attack, do not justify hasty resort to intra-cranial surgery simply because the patient or his family are submissive under the persuasive eloquence of the would-be operator.

I desire, to-night, to report a few cases which have a practical bearing on some of the fundamental principles of cerebral surgery, and I hope they will serve as a means of bringing out the views of others in this interesting field.

CASE I. *Trephining for Cortical Epilepsy Apparently the Result of Traumatism; Improvement, Followed by Death in Five Weeks.*—A child twenty-nine

¹ Read at the meeting of the Philadelphia County Medical Society, November 25, 1891. For discussion, see page 511.

² "The Field and Limitation of the Operative Surgery of the Human Brain," *Annals of Surgery*, July and August, 1885.

months old had, sixteen months previously, received a fall, and, on the second day after the accident, was seized with convulsions. Four months before he had been struck on the head by a falling clock; but no special symptoms followed this mishap. Since the second attack he had had spasmodic seizures occurring at frequent intervals nearly every day. He dragged the left leg a little; did not seem bright, and was still unable to talk. There was a slight tendency to draw up the mouth on the left side, and also an inclination to turn the head and body to the left. When his attention was directed to bright objects he would apparently try to look at them, but his eyes usually turned to the left. His hearing seemed to be dull; but, so far as could be determined, the cutaneous sensibility was unimpaired. No changes were found by ophthalmoscopic examination.

Dr. Charles K. Mills, who referred the patient to me, placed the child under observation in order to detect, if possible, the exact character of the spasms. He was watched carefully in several seizures. Usually he squealed at the beginning of the paroxysm, and his face had a vacant look. The spasm began with a lifting movement of the entire body, as if with the muscles of the trunk, much like a sudden effort to rise from a recumbent to a sitting position. About the same time, as nearly as could be judged, the eyes and head turned to the left. The eyes did not keep to the left, but oscillated with the jerking movements of the body; the head, however, continually turned to the left. The left leg and arm were spastic in slight flexion, and were lifted up and projected outward and forward. The limbs on the right side were flaccid, but were projected forward and upward with the jerking movements apparently communicated from the trunk and the left limbs.

Another description of the attacks records that the child awakened suddenly from sleep with a toss of the body, as if badly frightened, with the head and eyes at once turning to the left. The left arm was extended forward and upward, stiff and rigid, with the thumb and little finger pointing backward, the other fingers being slightly flexed. Both legs were also tossed upward in the air, the left more projected than the right. His body was lifted up and down during the attacks.

It was difficult to determine any signal symptom or serial order of movements. The spasm was both tonic and clonic, and certainly most marked in the limbs and face of the left side. The movements of the leg and arm were those of projecting and protraction, and were rather movements from the shoulder and hip than from and in the distal portions of the limbs. The movements of the head, trunk, face, and limbs were often nearly coincident, but the conjugation of the head and eyes seemed certainly to be most commonly the initial movement.

The above description is taken from a former report of the case.¹

Dr. Mills thought that the symptoms seemed to point to a lesion of the area for conjugate deviation of the head and eyes, and certain associated movements of the trunk, thigh and arm. It was, therefore determined to trephine over the posterior portions of the first and second frontal convolutions.

After encircling the head with a rubber bandage to prevent hemorrhage from the scalp, I made an opening with an inch and a half trephine placed one and a quarter inches in front of the fissure of Rolando, and

a little to the right of the median line. Behind and below the opening so made, I cut out another button of bone with a one and a quarter inch trephine. The spurs of bone between the two holes were cut away with forceps. One point of the dura was abnormal in thickness and rather more adherent than normal. This condition did not seem to be caused by a Pachionian body.

A flap of the dura was raised. The pia-mater was very cedematous so that it could be pitted with the finger. A thin, yellowish-white membrane was found lying loosely upon the pia-arachnoid and had probably separated from the dura when the flap of that membrane was raised. This abnormal membrane was removed. Small electrodes applied to the convolutions failed to induce contraction of the left arm. This electrical test was repeated but failed to give results, though no antiseptic solution had come in contact with the brain tissue before the electrodes were used. Incisions in the pia allowed the serum, which caused the cedema, to escape. When the convolutions were thus clearly exposed there was no evidence of change in their structure or of any subjacent lesion. The dural flap was then sutured in position, and the portions of bone, which had been kept in antiseptic solution at a temperature of 105°, were replaced. Some catgut threads were laid beneath the buttons of bone and carried through the incisions in the scalp to give drainage.

The child was under my observation for nineteen days, during which time there were only three epileptiform attacks, and these were within two or three days after the operation. They were all slight and would scarcely have been recognized as pathological symptoms if the previous severe attacks had not formed part of the clinical history. A large amount of cerebro-spinal fluid escaped for several days through the opening left by the catgut drain, which was removed a day or two after the operation, and also through a small hole in the line of incision which had not healed by first intention as had the rest of the wound.

Bromide of potassium, calomel, and small amounts of alcoholic stimulants were given to the child during the after-treatment.

When he was discharged from under my immediate care his general condition was good, temperature normal, and there had been no escape of cerebro-spinal fluid for three days. The two small openings in the scalp were covered with small crusts.

Two weeks later the child died, but the history of the intervening period is unknown. I heard only indirectly of his death. No post-mortem examination was made, but indefinite information has come to my knowledge, which leads me to believe that suppuration under the scalp occurred.

This case is one of a class in which there is a great temptation to operate in hope of finding some removable lesion of the cortical centers. The findings are usually negative; and the results only temporarily satisfactory, even when the patient entirely recovers from the lesions incident to the operation. Unless the localizing symptoms and signs are more definite than in this instance, I think that in similar cases I shall hereafter be almost inclined to avoid operative interference. This provisional conclusion has been reached by a consideration of cases in the treatment of which I have been concerned, or with whose results I am familiar.

CASE II. Traumatic Epilepsy Resulting from Undiscovered Fracture; Trephining with Discovery of an Irregular Protection of Bone on the Interior of the Cranium.—A man, J. H., aged thirty-four years,

¹ Polyclinic, April, 1889, p. 299.

while working as a puddler, about eight years ago, received an injury on the left side of the head by being caught between an iron lever of a furnace-door and a brick wall. He was treated by no physician, and only lost about two days from his work, although the injured region was poulticed by him, and was the seat of a discharge for four or five months. No portion of bone came from the wound, and there were no special symptoms.

Several years ago he had venereal sores upon the penis, but no suppurating inguinal glands or syphilitic developments. Chills and fever, several years ago, constituted the only illness from which he suffered.

An examination of his head, after shaving, revealed several insignificant scars, and just above the zygoma on the left side, a half inch in front of the auricle, a depressed cicatrix sufficiently deep to hold the tip of the little finger. This was the scar left by the injury received eight or nine years ago. The cicatrix involved the temporal muscle, as was seen by the dragging of the skin over the scar during mastication. There was no evidence of depression of the skull in any other part of the cranium, and this depression did not seem to involve the underlying bone. His intelligence was good; but the patient said that he did not remember as well as he could a few years ago, and that at times his eyesight was not good. He shows at times a little mental deterioration. An ophthalmoscopic examination of the eyes gave negative results.

The patient states that about two and a half years ago he had an epileptic fit after working in a hay field on a hot day, and that since that time he has had marked seizures about every six weeks, with lesser attacks more frequently. He has but one epileptic fit at a time, from which he rapidly recovers, and is soon able to walk about. After such attacks he feels weak for some time. For several years he has had severe headache, not confined to any one portion of the head, and just before the epileptic seizure he feels a jerking sensation on the right side of the nose. He complains that his general health has deteriorated, but there is no apparent loss of flesh.

On the 26th of September of the present year (1891) I turned up a large flap of the scalp and found, after cutting through the temporal muscle, a depression in the skull one inch in length and three-eighths of an inch in width. This fracture was a surprise to me because of the history of the case and the situation of the injury over the thick belly of the temporal muscle. A three-quarter inch aseptic trephine was applied above and behind the depression. This cut through the bone with some difficulty, because the upper portion of the disk was much thicker than the lower part. Unfortunately my segment trephine had been forgotten, or this part of the operation could have been more expeditiously performed. Thinking I had cut entirely through the skull, I endeavored to pry out the disk, but removed simply the outer table of the button; I found that between it and the internal surface there was a portion of fibrous tissue entangled. It was probably this portion of tissue entangled in the bony cicatrix as a result of the fracture at the time of the injury that enabled me to lift out so readily the upper surface of the bony disk. The entangled tissue was doubtless pericranium. Removal of the interior table of the disk revealed below and in front of the opening a teat-like elevation projecting from the lower surface of the skull and pressing upon the dura. This elevation was about one-fourth of an inch higher than the general surface of the interior table,

and was the apex of an irregular elevation due to consolidation of a number of comminuted fragments of the inner table. The irregular lines of fracture, with the fragments displaced in varying degrees, are shown on the button removed and the rest of the bone subsequently cut out with gnawing forceps.

The specimen shows this condition very satisfactorily, though somewhat mutilated by the gnawing forceps with which the adjacent bone was removed after the original button was taken out. The depth of the skull wound and the thickness of the temporal muscle made it rather difficult to operate neatly, and my desire to get rid of the portion of bone pressing upon the dura, without prolonging the operation or increasing its severity, caused me to sacrifice the specimen in the interest of the patient. The dura was not opened, threads of catgut were used for drainage and a dry sublimate dressing was applied.

The following day the wound was found to be healing by first intention, and the drainage threads were removed. Bromide of potassium and chloral were given for two nights; and then twenty grains of bromide of potassium three times a day were ordered as a continuous treatment.

On the third day after the operation the patient had a sensation of twitching at the side of the nose similar to that which formerly preceded the epileptic seizures; but he had no fit. The wound healed by first intention, the temperature never rose above 99.6, and on the eleventh day after the operation the patient was sent to his home in the center of the State. He felt exceedingly well after the operation and expressed his satisfaction at the improvement of his condition. I suggested that the bromide treatment be continued by his physician, Dr. J. P. McCleery, under the idea that removal of the surgical cause of epilepsy should be looked upon as only a part of the treatment. I believe that in all such cases internal treatment should be combined with surgical procedures, and that the epileptic habit should be controlled by a prolonged course of bromides after the mechanical cause has been removed.

Seven and a half weeks after operation his physician reported that he had suffered no return of his epilepsy and was about to return to work. As far as it goes this statement is gratifying, but much more time must elapse before we can feel sure of a cure having been effected. The lesion is certainly one of those in which trephining ought to be eminently beneficial. Punctured fracture such as this should always be subjected to immediate trephining at the time of injury.

Upon this card is a representation of the external and internal appearance of the skull in a case trephined by me some years ago. There was a small scalp wound through which I could with my fingertip feel what I thought was rough bone. I found by incision that the roughness was due to an unusually irregular lambdoidal suture with Wormian bones; and that the only bony lesion caused by the blow received from the pitcher, with which the patient was struck, was a small dent looking like the opening for the entrance of a vein. The character of the vulnerating force, however, induced me to trephine. The removal of the trephine button and the insertion of a probe between the dura and the cranium discovered nothing except a small fissure on the inner surface of the disc. Death occurred within a short time from alcoholic delirium; and the autopsy revealed a T-shaped fracture of the inner table with a shelf-like detachment of quite an area of bone. If this patient had lived he would probably have had secondary

epilepsy, as occurred in the case just reported. The urgent necessity of primary trephining in such punctured fractures, even when no symptoms are present, is fully illustrated by these cases. The many deaths from cerebral abscess and other inflammatory processes, following the receipt of punctured fracture of the cranium, long ago justified the surgical conclusion that trephining in such injuries should not be delayed until the advent of symptoms of encephalic inflammation. The epilepsies resulting in cases which have escaped the immediate dangers of encephalitis add another argument to the wisdom of immediate operation in punctured fractures.

FIG. 1.



Outer surface of fractured cranium showing lambdoidal suture, point where trephine was applied, and small indentation looking like entrance of a vein made by the blow.

FIG. 2.



Inner surface of fractured cranium, showing cut made by trephine, and large area of inner table driven inward under the small external indentation. The trephine has not cut entirely through the bone where the inner table is driven inward.

CASE III.—Second Trephining for Traumatic Epilepsy; Death from Aseptic Cerebral Inflammation.—In June, 1891, I operated upon a man, J. T., aged twenty-eight, with the following history:

While working in a mine he had been struck upon the head with a huge mass of coal and rendered senseless. The attending physician, Dr. James D. Garvey, found a fracture of the skull, and upon the day of the

injury removed a portion of the bone. According to the patient's statement he recognized no one for fourteen days, and was, therefore, probably unconscious during that time.

After consciousness returned his left arm was paralyzed, but gradually regained power. Eight months afterward he had an epileptic seizure, and has had epileptic paroxysms at irregular intervals ever since. He is aware of the approach of a convulsion by nausea, dizziness, and disorder of vision. Occasionally he has time, after the premonitory symptoms, to sit down before the fit occurs. He thinks that he ordinarily falls in the convulsion, but he does not bite his tongue at such times, though he froths at the mouth and grinds his teeth. The attacks have occurred as often as one or two in a day, but he has gone as long as four months without a paroxysm. The ophthalmoscopic examination reveals a normal fundus, clear media, and hyperopic refraction. He is unable to say in what part of the body the muscular spasm begins.

A large triangular depression is seen upon the right side of the head, the upper margin or base of which is one and three-quarter inches to the right of the median line and almost parallel to it. The apex of the triangle points downward and forward toward the ear. The anterior margin of the depression is near or a little behind the fissure of Rolando, and the center of the depression is over the superior parietal convolution, or in that vicinity. The deepest portion of the depression is that near the middle line of the skull, at which part its depth is fully a half inch; the edge of the depression at this point is almost vertical. The inferior and posterior borders are less abrupt. The angle, which I have called the apex of the depressed triangle, is about two inches above the ear, and a little behind a vertical line drawn upward from the ear. The margins of the depressed area form an equilateral triangle, each side of which is about one and one-quarter inches in length. There are a number of other scars on the head, one or two of which radiate from this depression. There is distinct weakness of the grasp of the left hand, but no marked difference in size of the hand or the arm. The patient complains of the left hand feeling different from the right. There is no muscular contracture and no apparent change in the electrical reaction or in mensuration.

On account of the epileptic attacks in this case I determined to operate and remove any apparent cause of irritation. If nothing abnormal was found, I intended to remove the cicatricial tissue in the bony gap, and also the bony margin of the opening in the skull. Accordingly I made an elliptical flap in the scalp, which disclosed a triangular depression in the skull corresponding with the indentation seen externally. This was filled in with fibrous tissue, which I dissected out of the bottom of the depression. The bone was so thick that the gnawing forceps could not cut away the edges; hence, I used an aseptic trephine, and removed a disc one inch in diameter from one corner. Subsequently I made four small holes along the edge of the depression with a half-inch trephine, and then was able to gnaw away the edges with gnawing forceps. The soft tissues were yellow, and pigmented in places with particles of carbon, evidently due to coal dust ground into the wound at the time of the accident.

Before the operation pressure upon the scalp gave the sensation of a small cavity filled with air under the integument. It resembled the sensation experienced when a varicose vein is palpated. Removal of

the skin over the gap in the cranium did not alter this tactile phenomenon. The yellow pigmented tissue, found as above mentioned, was not brain tissue; and when cut through disclosed what looked like the interior of an emptied cyst, because the inner surface of the tissue had a smooth, glistening surface. No fluid escaped or had escaped by puncture. After having dissected away a considerable portion of this material, and having removed the edges of bone along the entire circumference of the bony opening I reached normal brain-tissue. Hemorrhage from the cerebral wound and from the periosteum was profuse. It seemed impossible to stop that which came from the brain and its membranes, which were fused together in an almost indistinguishable mass at the bottom of the deep hole. The triangular opening in the skull measured about two inches along each margin. The pulse became very feeble, counting 165 a minute. Prolongation of etherization and operation seemed unwise.

After unsuccessful attempts to stop the bleeding by ordinary methods, I concluded to grasp all the bleeding points with hemostatic forceps, which should be left in the wound. This was done, and five forceps left in the wound with their handles protruding. Iodoform powder was dusted upon the surface of the exposed brain, and strips of iodoform gauze packed into the cavity. A few sutures were applied after the flap had been replaced; the gauze strips and hemostatic forceps projected from one corner of the wound. A voluminous dressing of iodoform gauze and cotton was then applied and the patient put to bed. Seven and one-half hours after the operation the dressings were saturated with bloody serum, and, therefore, in order to avoid sepsis, I determined to reapply them and remove the hemostatic forceps at the same time. This was done carefully, the gauze withdrawn, and the wound redressed with a dry antiseptic dressing. In drawing out the strips of gauze a little oozing of blood occurred, but this hemorrhage I did not think of sufficient importance to prevent my closing the whole wound with sutures and without drainage.

The next morning the patient showed great restlessness, but was in a condition of hebétude. He, however, made his wishes known when he desired to urinate. Bromide and chloral were given to control the restlessness.

On the second day respiration varied from 25 to 40 in a minute, and the temperature was 101°. During the day the patient's condition was fairly good, though he was difficult to control on account of his restlessness and irritation. The urine was passed unconsciously. A turpentine enema was given; bromide and chloral were continued. On the third day after the operation it was necessary to give the patient $\frac{1}{4}$ of a grain of morphine hypodermatically, and to strap him in bed because of his tossing from side to side. During the day he became hoarse, and I discovered at the base of the right lung harsh râles, probably bronchitic. The temperature was now 101.6°, while his respiration was between 35 and 40.

On the fourth day after the operation the note is made that he slept after a hypodermic of morphine— $\frac{1}{4}$ of a grain—and is quieter. Respiration, 40 to 45. His breathing, however, was embarrassed and harsh, somewhat of the Cheyne-Stokes' type. At 7 P. M. respiration was 50; temperature 102°. The wound had been left undisturbed since the evening of the operation when the hemostatic forceps were removed. The rise in temperature and the patient's restlessness made me fear that there had been something

amiss in my antiseptic precautions. I therefore determined to inspect the wound. Upon removing the dressing I found the flap bulging, and detected a feeling of fluctuation when my finger was put upon it. I expected to find pus under the flap, although the wound had healed by first intention. I tore open the union, but no evidence of pus existed; a soft, aseptic clot of blood, however, lay under the flap. I removed the clot and explored the cranial cavity through the operation wound with my finger in search for pus. The cerebral tissue was disintegrated and soft, but no purulent collection was found. I moved my finger in various directions in the pulsatous mass, and finally, when my little finger was buried its entire length, came upon a hard mass at the bottom. This, I presume, was one of the great ganglia. The tissue overlying this part was almost fluid. There was no odor of decomposition, nor evidence of pus. At the time of this exploration the patient was moribund, and I felt fully justified in these radical measures. Unless I found pus he was sure to die.

The dressings were re-applied; hypodermic injections of strychnine were given. Respiration gradually failed, and the patient died the next morning, which was the fifth day after the operation.

It seems hardly possible that the fatal symptoms were due to pressure from such a small amount of hemorrhage under the flap, since there was much space by reason of so much bone having been cut away; and, moreover, the blood, if causing tension, would probably have readily escaped before the wound had united. I concluded, therefore, that death occurred from aseptic cerebral inflammation leading to disintegration and softening of the brain tissue. The pulmonary symptoms may have been secondary; or he may have had a congestion, preliminary to an acute pneumonia, acting as a prominent feature in the fatal result. Rapid respiration was certainly an early symptom.

The case is to me exceedingly instructive, because the indications for operation were clear, and because death occurred notwithstanding what seemed to be perfect aseptic conditions of the wound, during its entire course. It is a good illustration of the fact that modern surgery has not rendered serious operations entirely devoid of dangers. The diminution of the death-rate in operations has been great in recent years, but certainty of recovery is by no means as absolute as some reporters of operations would have us believe.

The next case is reported because of the youth of the patient.

CASE IV. *Trephining for Depressed Fracture of the Skull in an Infant Seven Months of Age; Recovery.*—

A mother, while carrying her seven months' old child along a railroad track, fainted, or had epileptic seizure, and fell, dropping the child. When she regained consciousness the baby was whining and fretting a little, but did not seem badly hurt. After the mother reached home and removed the child's wraps, she discovered a large indentation of the skull on the right side of the head, which she supposed was due to the child's head having struck against a railroad tie, or upon the iron track. The baby did not have any symptoms of brain implication.

When seen by me on the next morning the infant was perfectly comfortable; had slept well all night; played as usual, and had a good appetite. The mother believed the depression to be less marked than when the accident occurred. Examination revealed an irregular depression in the parietal and

occipital region on the left side of the head. The lower extremity of the vertical diameter of this depression was about 2 centimeters above and 5 centimeters back of the top of the ear. The depression extended upward 6 centimeters. The horizontal diameter—that is, that parallel to the sagittal suture—began at a point near the anterior portion of the posterior half of the parietal bone, and extended backward 6 centimeters, very nearly bisecting the vertical diameter. The depression at its deepest portion was fully a centimeter below the surface of the skull.

At this time the patient's temperature was normal; pulse 120. During the night 2 grains of sodium bromide were given because of slight restlessness. The bowels were opened by a soap suppository.

On the second day after the accident I found the child feeling well and the depression less marked than on the previous day, when I made the first examination. I felt unwilling, however, to let the injury go without surgical treatment, and therefore determined to make at least an exploratory incision, because the injury had been so severe as to make a very deep depression. The possibility of secondary symptoms, such as epilepsy or impaired intellect, seemed to me to indicate this slight operative interference.

An Esmarch's bandage was carried around the head before the incision was made, to prevent bleeding. A horseshoe flap was then dissected up at the point of injury. The bone was markedly depressed, showing a condition similar to green-stick fracture. I thought I could cut through the cranium with a strong knife, but found it necessary to use a trephine. A small trephine opening was made through very thin bone at the anterior edge of the depression, and the portion pushed down upon the brain easily elevated with the end of a grooved director. A few bleeding arteries were twisted, and the edge of the scalp wound drawn together by catgut sutures. Boric acid powder and dry sublimate dressing were applied.

The patient reacted from ether promptly, and went quietly to sleep. Two-grain doses of sodium bromide were given at intervals until 10 grains had been taken. The patient was restless through the night, but a few drops of paragon quieted him. The bowels were kept open by injections of oil.

The temperature, the day after the operation, reached 101.8° ; but soon all symptoms of fever disappeared, and on the seventh day the dressings were removed. The wound was found to have healed by first intention without suppuration.

At the end of the sixteenth day the patient was sent to his home in New Jersey entirely recovered.

In this case the accentuated character of the depression was the factor which led me to adopt operative procedures, although I know the tendency for depression of the skull in healthy infants to correct itself spontaneously.

About eighteen months ago, I saw a child who had received, during birth, a very marked indentation of the skull, because the head had become locked on the promontory of the sacrum during delivery. The depression was situated on the left side of the head, and included portions of the frontal and parietal bones near the anterior fontanelle. It was about two and a half inches long and quite deep. The case was one of difficult labor, requiring forceps at the hands of Dr. Anna M. Fullerton, and the child, when born, was in the first degree of asphyxia, requiring the warm bath and artificial respiration. The child had

frequent convulsions, beginning twenty-four hours after birth, evidently due to implication of the brain; yet I declined to operate because I thought that the indentation was probably not associated with actual fracture of the soft bone. The convulsions ceased within twenty-four hours, and although the patient was under observation for several weeks, I never could convince myself that operative procedures were justifiable. The depression gradually lessened, and when the child was last examined by me, seemed unimportant. The medicinal treatment of the child consisted of sodium bromide and potassium iodide. I have sometimes felt, in regard to this case, that the subsequent history might, perhaps, show that it would have been better to have interfered. I have not been able, thus far, to succeed in tracing the subsequent history of the little patient.

CASE V. *Specimens of Cerebral Tumor Which Could Have Been Readily Removed by Surgical Means.*

—The brain herewith presented shows a tumor occupying the parietal region, and was obtained from a subject in the dissecting-room of the Woman's Medical College of Pennsylvania. The history of the case is, therefore, exceedingly indefinite, though, through the courtesy of Dr. George S. Robinson, I have been able to obtain the following notes:

The patient was a woman, aged thirty-five years, of intemperate habits, who had, so far as known, no injury of the head and was not discovered to be syphilitic. She was an inmate of a public institution, and was sent to its infirmary about a week before her death, complaining of pain in the head which seemed to be somewhat relieved by pills of an anti-neuralgic character. The headaches continued, however, notwithstanding medication, and, for about two days, vomiting occurred. The patient then became comatose, and paralysis of the right arm and leg supervened. The pupils were somewhat dilated and did not respond to light. Respiration was slow and the face flushed. No convulsions occurred, but there was slight twitching of the facial muscles. The patient was not noticed to be blind or deaf. Death took place on the sixth day after admission to the infirmary.

An examination of the specimen shows a flat, circular tumor in the right parietal region lying between the dura mater and the cerebral hemisphere. The convolutions are pushed downward by the growth, but are not infiltrated in the least degree. The dura has not been preserved, but it is quite evident that the growth was attached to the inner surface of the dura, since its upper surface is torn and it has no attachments to the convolutions, but can be lifted out of its bed without disturbing their integrity. The tumor is almost circular when inspected from above, being 6 centimeters in the antero-posterior diameter, and 6.5 centimeters in the transverse diameter. It is flat from above downward, varying from 2 to 3 centimeters in thickness. It occupies the right parietal region upon the superior aspect of the cerebrum. Its anterior margin lies in a line with the callosomarginal fissure, and pushes forward the ascending parietal, or posterior central, convolution. The tumor extends backward to the parieto-occipital fissure, crowding downward and backward the first occipital convolution. It extends outward and downward to the posterior end of the parallel fissure, or the first temporo sphenoidal fissure, pressing upon the angular gyrus. The first and second parietal convolutions are flattened, and lie underneath the tumor in the concavity made by its growth producing pressure downward. On the inner aspect of the hemisphere, the tumor presses the convolutions downward, being

nearly two centimeters thick where it lay in contact with the falx. The anterior edge of the tumor is about one centimeter further downward than the posterior edge of the corpus collosum. The gyrus fornicatus and the precuneus are pressed downward, but the cuneus does not appear to be pressed upon or displaced.

No surgeon can look upon this specimen without a feeling of regret that he could not have had an opportunity to attempt its removal. Its location immediately under the dura, its freedom from attachment to the cerebral convolutions and its moderate size would have made its removal easy. Its location behind the motor area is probably the reason that the patient's symptoms were not marked until just before the fatal termination of the disease. Her habits of life and surroundings were such that she would not

FIG. 3.

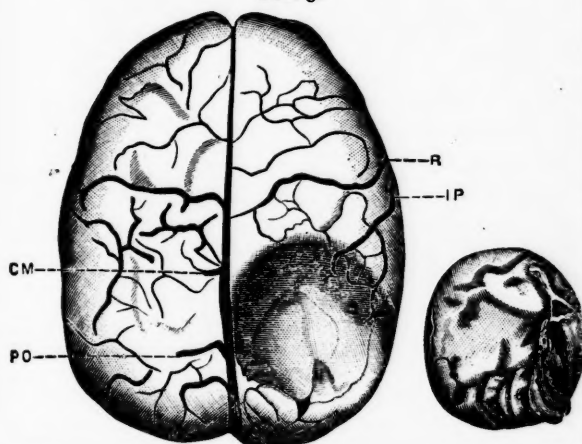


Diagram showing relations of brain tumor. R, fissure of Rolando; I P, inter-parietal fissure; P O, parieto-occipital fissure; C M, callosal-marginal fissure. The tumor has been lifted out of its bed.

be likely to call a physician's close attention to the early manifestations of cerebral disorder, if indeed these were apparent to the patient herself. A large opening made with trephine, gouge, or saw, followed by a similar incision of the dura would have enabled the operator to lift the tumor from its bed without hemorrhage or disturbance of the cerebral convolutions. The growth is probably a fibroma.

The occurrence of right-sided paralysis seems rather curious, but Dr. Robinson states that he is sure of the correctness of this note, for he remembers that she used her left hand during her final illness. There is no evidence of a second tumor on the left side. Possibly the growth may have so pressed against the falx as to have impeded the current in the superior longitudinal sinus, and thus have given rise to pressure on the left cortical centers near the upper end of the fissure of Rolando. Unfortunately, I did not see the specimen until after the dura and falx had been removed.

CASE VI. Probable Basal Cerebral Tumor in which Operation was Deemed Inadvisable.—In September, 1889, a man, aged thirty-four, was referred to me by Dr. H. C. Bloom, who had reached the conclusion that his patient was probably suffering with brain tumor. The history was somewhat difficult to obtain from the patient, who had evidently some impairment of mental faculties. In childhood he had otorrhœa in each side, and thought that his present ailments, of two or three years' duration, had succeeded a renewed discharge from the left ear. About a year be-

fore I saw him he had fallen insensible; but for a year and a half previously he had had attacks of severe pain in the head, to the left of the median line. Some failure of vision had been observed for eighteen months; occasionally he walks unsteadily, but there is no apparent loss of power in arms or legs. His family thought his mental traits had shown change for several years. He is now becoming fat, sleeps a good deal, and is somewhat "weak-minded" in his conversation and facial expression. There was no direct history of syphilis. Optic atrophy was found in both eyes; being more marked in the left, with which he could only see enough to count figures.

The vision of the left eye was $\frac{4}{1X}$. Examination showed him to have lateral homonymous hemianopsia and Wernicke's pupillary reaction. The fields of vision indicated a left-sided lesion. No deviation of the eyes was determined, but he thinks he has at times had double vision. Both tympanic membranes were perforated. He had had no epileptic seizures, but, as above stated, had once fallen unconscious. The urine had a specific gravity of 1010 and contained neither albumin nor sugar. The grasp of the right hand was stronger than the left, accountable perhaps to his profession—that of a dentist. Thermometric examination for several days showed him to be free from fever.

No anæsthesia nor paresis could be determined. Dr. B. Alexander Randall's examination resulted in finding in the left ear an old cicatricial condition, with a mere trace of discharge. The original trouble had probably been present in childhood, and was now in abeyance; though occasional exacerbations had in all probability occurred. The right ear was in a state of chronic suppuration of the attic and adjacent cavities, with some likelihood of the existence of diseased bone. No involvement of receptive or central auditory apparatus was discovered by the use of tuning forks. The patient's symptoms were thoroughly studied for me by Drs. Charles K. Mills, H. C. Wood, Edward Jackson, B. A. Randall, and A. W. MacCoy.

From Dr. William Osler, who had seen the man some months before, I learned that then he had had an intense optic neuritis, but at that time no hemianopsia. Dr. Osler suspected a slowly growing neoplasm; probably located in an anterior location because of the early alteration in habits.

Dr. Mills was inclined to think that the symptoms shown when the patient came under my care pointed to a lesion between the optic chiasm and the primary optic centers. This he considered might be a tumor or abscess of the inner part of the temporal lobe, encroaching on the optic tract back of the chiasm; or a similar lesion of the cerebellum advancing and invading the more anterior structures.

Dr. Wood believed the localizing symptoms pointed to a lesion encroaching upon the corpora quadrigemina or optic chiasm, which was most probably either a localized meningeal inflammation with much exudation, due to diseased bone at the base of the skull, or a tumor there situated. He thought it possible that an abscess might exist in the temporal or frontal lobe, but there was little evidence to indicate this being a probability.

This case was one that offered a good many points of surgical interest; but, after determining that the lesion was probably basal and on the left side, I declined to operate, because there was no evidence of the left ear being a probable cause of intra-cranial suppuration. If the symptoms had pointed to a right-

sided lesion, the condition of the right ear would have influenced me strongly toward operative measures, looking to the evacuation of a temporal abscess. The association of chronic aural suppuration with cerebral abscess is so well known that I think I should have strongly inclined to exploratory trephining.

I accordingly declined to operate, and sent the patient home. I heard from him frequently, but he gradually lost vision and mental power. I had arranged for, and obtained permission for, an autopsy; but when he died the past summer no word was sent me. Previously to death he had violent pain in the head, a prolonged chill, several successive convulsions and coma with high temperature. These symptoms occurred suddenly and terminated fatally in four days. Before that time he thought his eyesight, which had been almost totally lost, was improving. The time he survived after my examination, nearly two years, leads me to believe that our abstinence from operation was correct; since the lesion was more probably a tumor than an abscess. If a tumor, its removal was certainly impossible.

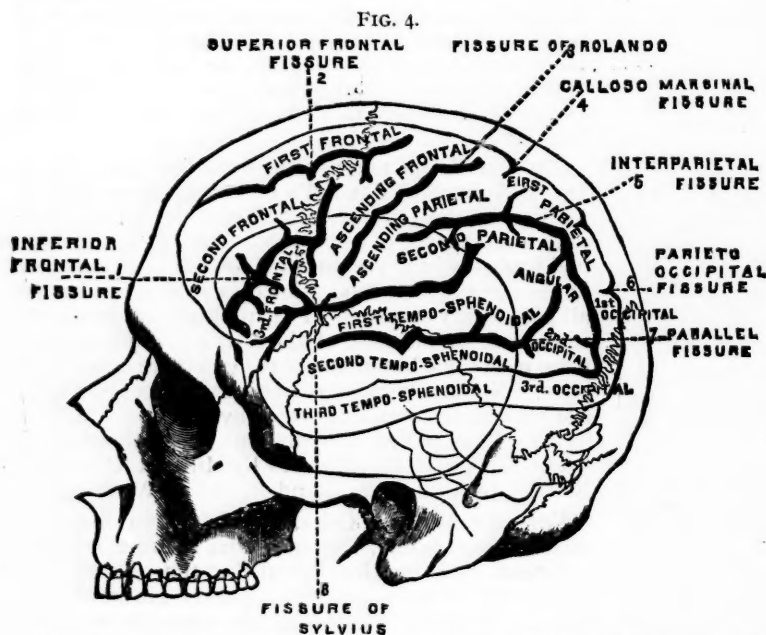


Diagram showing lateral view of the cerebral convolutions and fissures, to aid in making the description clear.

This case presents a picture different from the specimen before you, in which the tumor could have been lifted out so readily. I show a diagram of the cerebral convolutions, which may aid in following the description of these two cases of cerebral tumor.

I fully recognize that the record of these few cases has not been one of brilliant results. The death of some of the patients, and the short time between operation and this report in others, make the communication in some respects unsatisfactory. It has seemed to me, however, that there are elements of interest in the histories which will afford food for thought and open the way to discussion. It is for these reasons that I have been tempted to give these clinical histories, which are certainly not in any way remarkable.

THE best action of the famous 400 so far is the formation of a society for the distribution of Christmas candy and Christmas gifts. They could easily make many times 400 happy and yet not feel the gift.

MODIFIED JUNKER INHALER, WITH POINTS FOR DISCUSSION ON ETHER AND CHLOROFORM NARCOSIS.¹

By MARIE B. WERNER, M.D.

MY object in presenting this inhaler before the society to-night is not alone because I consider it the best of its kind ever brought to my notice, and, therefore, concluded it might be of interest to some of the members here to-night, but also to learn something about the pros and cons regarding the use of ether and chloroform as anæsthetics.

The inhaler has the respiration indicator approved of by the Hyderabad Chloroform Commission, and, in addition, has a graduated stop-cock which will, if properly adjusted, control the volume of air forced through the bottle containing the anæsthetic, thus giving a continuous current.

The bottle should be but partially filled—4 to 7 drachms—thus allowing the contents to pass over through the tube to the face-piece in the form of vapor. If chloroform is used, with one compression of the

bulb 5.19 cubic inches of air are forced through the liquid, and will evaporate, in a temperature of 68° F., about 1 minim; a trifle more than one cubic inch of the vapor passes through the short tube into the face-piece.

The noteworthy points are that the patient does not inspire much, if any, of the expired air; the apparatus is clean, and can be kept so with little trouble; the quantity of the anæsthetic used is comparatively small; and last, but not least, perhaps, the character of the respiration is always indicated to the operator as well as the anæsthetizer.

The character of the respiration seems to be of vast importance, if we accept the report of the Hyderabad Commission, based upon an almost unbroken series of 45,000 cases of chloroform administration, extending over forty years, in which the anæsthetizers were guided entirely by the respiration, and there was not a death. In strict accordance with these clinical facts, the experimental data of the Hyderabad Commission prove—²

"1. That the administration of chloroform is free from risk if the breathing is perfectly regular throughout and the inhalation is stopped as soon as the animal is fully under its influence.

"2. That chloroform never causes death by sudden stoppage of the heart.

"3. That death from chloroform is always the result of an overdose.

"4. That the danger of overdosing is enormously increased by holding the breath, struggling, asphyxia, or anything which causes the patient or animal to take gasping inspirations.

"5. That the inhibitory action of the vagus nerve, which is called into play in threatened and actual poisoning with chloroform, is a safeguard."

¹ Read before the meeting of the Philadelphia County Medical Society, November 25, 1891. Discussion, page 512.

² *Lancet*, November 29, 1890.

I do not wish to give the impression that I advocate chloroform in all cases, but think many will admit that there are cases where it has advantages over ether, provided it can be given with safety to the patient. For instance, in cases of bronchorrhoea it is less stimulating to the mucous membrane; in certain pathological conditions of the kidneys it can be relied on with greater safety. Last, and perhaps not least, to be considered is the small quantity necessary for a large operation, thereby possibly obviating some of the unpleasant after-effects of ether, notably the nausea, vomiting, and depression which sometimes follow a prolonged operation.

There is one point I have not yet been able to develop, and that is the utility of this apparatus in giving ether. Although I have been assured it would behave satisfactorily, I have not had sufficient opportunities to demonstrate it with any degree of certainty to myself; but feel sure, however, if it could be utilized it would mean economy of ether and greater comfort to the patient.

This inhaler may be obtained from Messrs. Krohne & Senseman, London.

THE AMERICAN PHYSICIAN IN LITERATURE.¹

By E. L. B. GODFREY, A.M., M.D.

MR PRESIDENT AND GENTLEMEN OF THIS SOCIETY: The latter part of the eighteenth century witnessed the dawn of American literature. It first arose in the form of theological discussions, due to the enjoyment of religious liberty and the superior attainments of the clergy. The desire, however, for political freedom gave birth to the great oratorical speeches of our forefathers, which occupied the front rank in the literature of the early part of this century. Contemporaneous with these were the beginnings of American poetry, fiction and journalism, and, since then, such rapid progress has been made in all forms of literature that to-day America stands adorned with gems of thought whose brightness is undimmed in the presence of the richest treasures of the ages.

HISTORY.

No department of literature has been cultivated in this country with greater credit to authors than history. Untrammelled by political authority, the American historian has been free to connect the events of the past with those of the present and to impart to them his own convictions. Nor is this all. The diversity in sentiment of the different nationalities meeting on common ground; the necessity of urgent action in tilling the soil and providing for physical comforts; the dangers and adventures incident to border life; the liberty of speech and religion; the freedom of the press and the political opposition to the mother country, all tended to beget a people unsurpassed in their independence of thought and action and self-reliant powers. The very actors in American history have given inspiration to historic pens, and, in recounting their deeds, a narrative has been produced that reflects the greatest liberty and progress known to mankind.

If the works of our early historians seem crude, and tinctured with an ancestral philosophy that we of this day will not acknowledge, the splendid scholarship of George Bancroft, Jared Sparks and

Benson J. Lossing has not only placed the rich data of the past upon an enduring literary basis, but has pictured for posterity acts of heroism and patriotism unparelled in the history of the world. To this rich display of historic learning, which Gibbon, Hume and Macaulay would have honored, the medical profession has contributed no small part. In the early period of the Revolution, there sprang from the loins of the medical profession a man whose work is still stamped with the seal of literary and historic approval. Dr. David Ramsey bears the honored title of the Historian of the Revolution. He was born in Lancaster, Pa., in 1749, and, after graduating at Princeton and in medicine, he entered upon the practice of his profession at Charleston, S. C. Of great professional and literary industry; an ardent patriot and a fluent orator, he early espoused the cause of his country, and such was his influence and force of character that he successfully opposed, amidst great opposition, the confiscation of the property of his neighboring loyalists. He entered the Continental army as surgeon and, in 1780, was captured and held with others as hostage by the British. He served as a member of the Continental Congress of which, in 1785, he was acting president. He wrote "A History of the Revolution," "A History of South Carolina," "A History of the United States" and a "Life of Washington."

Not less influential was Dr. Benjamin Rush, of Philadelphia. Of the highest professional and social position, Dr. Rush was not only a leader in his profession but also in politics. His prominence led to his election to Congress where he became distinguished as a fluent speaker and an ardent patriot. He served as surgeon-general of the middle division of the Continental army and was a close friend of Washington. Together with Drs. Walcott and Lyman Hall of Connecticut, he signed the Declaration of Independence, and was a member of the Pennsylvania convention that ratified the Federal Constitution. In medicine, Dr. Rush rose to the highest point of professional distinction. His polished manners, his classic attainments and his love for his profession caused his election to a professorship in the University of Pennsylvania, while his efforts in the yellow fever epidemic in 1793, where he was accredited with saving six thousand souls, have made him forever famous as a benefactor of mankind. Dr. Rush was one of the founders of the Philadelphia Dispensary and of Dickinson College. His contributions to medical literature were numerous, but his political essays and his public letters, his deeds in the field and his orations in Congress were the making of history.

I might further prolong the contributions of medical men to history, but the time assigned me will not permit. But there are some whose works are of such historic value that their names should not be omitted. Dr. Cadwallader Golden, of New York, wrote, in 1761, "The History of the Five Indian Nations"; Dr. Arthur Lee, of Virginia, famous as a Revolutionary leader and secret agent of the government abroad, composed the historic letters of "Junius Americanus"; Dr. James Thatcher, of New England, a surgeon of the Continental army, wrote "A History of Plymouth"; Dr. Isaac S. Mulford, a former member of this society, wrote "Civil and Political History of New Jersey"; Dr. Stephen Wickes, of Orange, N. J., wrote "The History of Medicine in New Jersey, and of the Medical Men from the Settlement of the Province to 1800"; Dr. John R. Stevenson, a member of this society, wrote "Medical His-

¹A speech delivered at the Semi-annual Banquet of the Camden County, N. J., Medical Society, November 10, 1891.

tory of Camden County"; Dr. Abram Clark, a "Medical History of Hudson County"; Dr. J. B. Somers, a "Medical History of Atlantic County"; Dr. John Blane, a "Medical History of Hunterdon County"; Dr. John S. Cook, with others, a "Medical History of Warren County"; Dr. Maurice Beesley, a "History of Cape May County"; Dr. Bateman, a "History of Cumberland County," and Dr. Forman, a "Medical History of Hunterdon County."

POETRY.

The first fruits of American poetry were Indian ballads and patriotic songs. These soon gave way to poems of graceful form and wider interests, culminating in the masterpieces of the most illustrious of American poets, William Cullen Bryant. More than any other, Bryant has consecrated by his poetic art the beauty of our land, the faith of our fathers and the spirit of our institutions. In this field, where the sympathetic Longfellow, the graceful Willis, the imaginative Drake, the psychological Dana, the patriotic Whittier, the descriptive Lowell, the fearless Whitman and the philosophical Bryant have set the standard for the nation, the medical profession has furnished several famous contributors.

Ranking among the first of American poets, both in point of time and precedence, is Dr. Oliver Wendell Holmes, of Boston. To him may be conceded the place of honor among living poetic writers, unless that be reserved for the beloved patriot, John G. Whittier, or our distinguished townsman Walt Whitman. What Washington Irving is to American *belles-lettres*, Fenimore Cooper to American fiction and George Bancroft to American history, Dr. Holmes is to American poetry. He is acknowledged to be the Alexander Pope of America, possessing the brilliant talents of the Englishman unmarred by his physical and mental defects. You are familiar with his poetry, his novels, his essays and his contributions to medical literature. In all of these departments, he has received high honors. His charming and unaffected style, his clear insight into character and his vivid delineations of New England scenes mark him as the most popular of living American writers. Omitting Dr. James G. Holland, of New York, and Dr. S. Weir Mitchell, of Philadelphia, of whom I shall speak later, I have no hesitation in saying that Dr. Abram Coles, of Newark, N. J., is, next to Dr. Holmes, the most distinguished poet that the medical profession has produced. His literary distinction and his wealth proved no inducement to him to relax his professional work, for which he manifested a strong affection. He received the degree of A. M. from Rutgers; Ph.D. from Bucknell, and LL.D. from Princeton. In 1865, when President of our State Medical Society, he delivered the annual address in poetry. The title of the poem was "The Microcosm," and in it he describes with classic dignity and sympathetic fervor the mission of the physician, and introduces as illustrations the famous paintings "Vesalius Engaged in Dissecting," "Harvey Demonstrating the Circulation of the Blood," and "Rembrandt's Lessons in Anatomy." No one can read this poem without a profound respect for the elegant diction, the familiarity with the classics and the touching love for the profession displayed by the author. Dr. Coles wrote many other poems, but his translations of Latin hymns and Hebrew psalms have made him the most famous of American translators.

It would require the entire time allowed me to recite the names and works of the poet-physicians of America. Yet gladly would I do this, for how grateful, how pleasing it is to know that in the medical profession, from among the men whose lives are spent under the dark shadows of pain and sorrow, there are found those who can push aside the solemn realities of life and break forth into joyous and poetic song. There are some names that cannot be omitted without doing injustice to the subject. Drs. Samuel George Morton, William Hunt, Caspar Morris, Thomas Wistar, John K. Mitchell, J. Aitken Meigs, and S. Solis-Cohen, of Philadelphia; Drs. James R. Orton, Benjamin Prime, and Samuel L. Mitchell, of New York; Dr. Jacob Bigelow, of Boston; Dr. M. N. Baskett, of Missouri; Dr. Lemuel Hopkins of Hartford; Dr. James B. Coleman, of Trenton, and Dr. T. J. Duffield, of Orange, N. J., and many others are known as graceful poets and verse writers, and illustrate both the scholarship of the profession and the taste and spirit of the times.

FICTION.

Unlike poetry, the prose element of literature has predominated during the years of peace in our national existence. The first English novel was written by Samuel Richardson early in the eighteenth century. The first American novel was produced by Charles Brockden Brown, of Philadelphia, at the beginning of the nineteenth century. Since then there has been no lack of native fiction; indeed, this is the day of novels, and the result of this craving for fiction is to weaken thought and ideas and nourish the superficial in intellectual life. Romantic fiction in America reached its height in the novels of J. Fenimore Cooper and Nathaniel Hawthorne. The modern realistic school may be said to culminate in the productions of William Dean Howells. In this field of literature, which to day is more fully occupied than any other, except journalism, the medical profession has many distinguished representatives. Dr. Holmes is again a conspicuous figure. Dr. Robert Montgomery Bird, editor of the *United States Gazette*, about 1830, wrote a number of novels that rank with those of Gilmore Sims, Dana and Longfellow. Dr. William Mayo's novels met with extraordinary sale. But there are three names that stand conspicuous in the front rank of men of letters, which the medical profession may well be proud of. One has passed beyond the boundary line of mortality, but still lives in his writings, which are accorded a perennial popularity. I refer to Dr. J. G. Holland, editor of the *Springfield Republican* and of the first *Scribner's Monthly*. Dr. Holland was a novelist of high rank; a brilliant essayist; a poet both witty and wise, and a true friend to humanity. The other two are still in our midst and active in our profession—Dr. William A. Hammond, of New York, and Dr. S. Weir Mitchell, of Philadelphia. In the rôle of novelist Dr. Hammond has attained a widespread fame, and shows a high degree of literary skill. He possesses a clear and graceful style; a keen appreciation of nature's beauty and grandeur, and a natural talent for story-telling. His grasp of character is synthetic, and his methods are those of the late romantic school.

Dr. Mitchell, of whom Philadelphia has reason to be proud, possesses a most versatile genius. As a poet he has won high praise for the beauty and elegance of his verses; as a dramatist he has had the pleasure of witnessing the successful production of his play by a famous actor; as a novelist he has gained laurels that are unfading. He ranks as one

of the most powerful and skillful of fiction writers. He is a realist in the best sense of the word; a keen analyst; a master of plot and climax, and a close student of life in this complex nineteenth century. The novels of both Dr. Hammond and Dr. Mitchell reflect credit upon them and honor upon the profession of which they are illustrious members.

OTHER DEPARTMENTS IN LITERATURE.

There are still several departments of literature in which American genius has been nobly illustrated by American physicians. In biography, Drs. Charles Caldwell, Samuel D. Gross and J. M. DaCosta and others, have won lasting fame. In explorations, the works of Drs. Elisha Kent Kane and Isaac Israel Hayes have become standard authorities of reference. In magazine literature, Dr. Reynold Coates, a former member of this society, won a wide and brilliant reputation. He wrote "Leaflets of Memory" and "The Gambler's Wife," in addition to a work on physiology and medical practice, and was an intimate associate of N. P. Willis and Edgar Allen Poe. In politics, he also became distinguished, and, in 1852, was nominated for Vice-President on the Native American ticket, with Daniel Webster for President. In this department, the contributions of Drs. Henry Hartshorne and Horatio Wood, of Philadelphia; Edward H. Clark and Henry T. Biglow, of Boston; T. Gaillard Thomas, of New York; John S. Billings, of the United States Army and Edward Stuppen of the Navy, and others, have made the medical profession famous.

And now I beg your indulgence while I briefly recite the work of a man for whom this society entertains a profound respect. I mean Dr. Ezra M. Hunt, of Trenton. Dr. Hunt has contributed to Biblical literature a work of two volumes known as "Bible Notes for Daily Readers," which links together the writings of the Old and New Dispensation, the history and prophesy of the Bible, rendering them intelligible to modern readers, and which has received the unstinted approval of the religious press. As one of the editors of the *New York Independent*, and as Secretary of the New Jersey State Board of Health, he has, perhaps, contributed more to sanitary literature than any man in America.

In this connection, let me ask, what have the medical men of New Jersey contributed to the common fund of knowledge? I shall not attempt to recite the names and works of all, for, did the time permit, I confess my inability to do so.

In History.—May be found the names of Isaac S. Mulford, Stephen Wickes, John R. Stephenson, Abram Clark, John Blane, John S. Cook, S. B. Sowers, Maurice Beesley, Rush Bateman and B. A. Watson, the author of "A Historical Sketch of Surgery."

In Poetry.—Abram Coles, James B. Coleman, the accomplished artist and brilliant author of the poem "The Cities of the Plains," and J. F. Duffield, the author of the splendid poem, "The Physician Himself," published in the *Transactions of the State Society*, in 1887.

In Theology.—Isaac Brown, Jonathan Dickenson, the first president of Princeton, and Joseph F. Garrison, a member of this Society, professor of liturgics, canon law and ecclesiastical polity, in the Episcopal Divinity School of Philadelphia, and, perhaps, more thoroughly versed in church and masonic history than any man in New Jersey.

In Legal Literature.—Charles G. Garrison, member of the Supreme Court of New Jersey; J. S. Whit-

taker, member of the Court of Errors and Appeals; E. L. B. Wales and others.

In Politics.—United States Senators John Condit and Jonathan Elmer, and Governor William A. Newell.

In Arms.—Major General Peter I. Stryker, General Ebenezer Elmer, General John Blane and Colonel J. Howard Willets.

In Journalism.—E. P. Townsend, William Perry Watson and Joseph Parrish, the founder of the *New Jersey Medical Reporter*, in 1847, which, in 1860, was removed to Philadelphia by Dr. S. W. Butler, and given the name of the *Medical and Surgical Reporter*. In the "literature of inebriety," Dr. Parrish stands unrivaled.

In General Literature.—Edgar Holden, Reynold Coates, Ezra M. Hunt, Maurice Beesley, Samuel H. Pennington, T. T. Price, Henry R. Baldwin, B. A. Watson, James B. Coleman, D. C. English, Abram Coles, Surgeon-General Varick, H. Genet Taylor, T. F. Duffield, John Blane, senator, general and historian, and Thomas F. Cullen, a former member of this Society, who was not only a brilliant musical composer, but also a dramatist and the well known author of "Observations of the Civil War on American Medicine and Surgery."

In Teaching.—Reynold Coates, Sylvester Birdsall, and Dowling Benjamin, all members of this Society.

In Philanthropy.—William O'Gorman, ex-president of the State Medical Society, fellow of the Royal College of Surgeons, of Ireland, and founder of St. Michael's Hospital at Newark; Sylvester H. Hunt, the founder of the Monmouth Memorial Hospital at Long Branch, and Richard M. Cooper, a former member of this Society, and founder of the Cooper Hospital of our city.

And now I know that I have trespassed too long on your indulgence and have greatly exceeded the time assigned me. My deep interest in the subject must alone plead my excuse. In conclusion, let me say, into whatever department of life you may look, whether in science, literature, art, theology, law, arms, discovery or invention, you will find that the American physician has exerted an influence powerful and beneficent, and when the importance of the physical well-being of the people and the mighty powers of sanitary science are understood by the Government, the medical profession will advance into a still broader sphere than it has yet occupied.

WHAT THE EYE REVEALS TO THE PHYSICIAN IN THE DIAGNOSIS OF DISEASE.

BY GEORGE S. HULL, M.D.,
CHAMBERSBURG, PA.

IN meeting our patients, even before going through the customary act of feeling the pulse and examining the tongue, we look, if ever so cursorily, into their eyes. And why not give these organs a more than passing glance? May we not find in them signs which will be of great assistance to us in the diagnosis of diseases elsewhere? This is the question I propose discussing with you as fully as the limited time at my disposal will permit; the largeness and importance of the subject, however, are such that it would well bear an evening's study together. To the physiognomist the eye tells much of the character of the person studied; the window through which the soul looks, frames a picture, which he at once recognizes as pleasing, or the reverse, and is prepared to govern his actions toward the individual accordingly. For practical purposes, however, the

physician need not possess the occult power of one, who by special training, learns to read so correctly the characters of those around him; what he should mainly question the eye for is, that he may read in its tissues that which may aid him in the diagnosis of disease. It is true that what he learns from the expression of this tell-tale organ may aid him much in addressing himself to the patient, and in placing the proper value upon the answers given to his questions; but what he learns from the physical examination of the eye and its immediate surroundings is of far more value to him.

It is to this physical examination we ask your attention, briefly, dividing what we have to say into two parts, viz.: what we may learn by the unaided eye, and what by the assistance of the ophthalmoscope.

1. It needs not much diagnostic acumen to discover in the eye and its surroundings the signs which point to the licentious man or to the drunkard, and a mere glance is often sufficient to convince us of a scrofulous cachexia, or even of the presence of syphilitic infection. The anæmia of phthisis and other grave diseases glistens in the pearly scleræ; jaundice floats its yellow flag boldly there, and uræmia opens wide the doors of the pupils as though presaging the soul's speedy escape. The protruding balls, with their scarcely closing lids, make us look downward to the thyroid, and thence to the heart for the dangerous exophthalmic goitre. And so, without even more closely examining the organs of vision, we are given direction in our inquiries into disease.

But to particularize, let us look more carefully at the changes the eye may take on as indicative of disease elsewhere. In the swollen lids, with their red and sometimes suppurating edges, we often see the first indications of a strumous diathesis, and to this same conclusion we are frequently driven by the appearance of phlyctenular conjunctivitis or keratitis—errors of refraction, however, must not be overlooked in the examination of such cases. Swollen lids, without inflammatory signs, should by their puffiness suggest to us renal or heart disease, or the overloading of the system with arsenic. In the newly-born, purulent ophthalmia warns us that the germ of gonorrhœa is somewhere in the home, and in the older grown may enable us to locate it on the patient himself. Obstruction of the lachrymal duct, with its annoying results, lead us to examine the nasal passages for catarrhal disease. The red, suffused eyes of measles makes us more sure of our diagnosis when other eruptive diseases are about. Looking still more minutely at the structures of the eye we may occasionally find the parenchymatous form of keratitis, and when recognized we at once turn our attention to the teeth, and look for the notched or concaved incisors, so well described by Hutchinson, and, then, according to this eminent authority, we say we have evidences of inherited syphilis; the same diathesis we may believe to exist, or at least a scrofulous or rheumatic one, when we view the ravages of the recurrent attacks of episcleritis.

Looking deeper into the eye we may find in the rough edges of the iris, or in present synechia, the signs of an old iritis; or, in the contracted pupil, the dull colored iris, coupled with the characteristic neuralgic pains, recognize the occurrence of a present attack; here we are led again to think of syphilitic taint, or of the rheumatic or gouty diathesis, for iritis not caused by traumatism is of rare occurrence in a good constitution.

When we see the rapid formation of double cataract in the young or middle aged, we should always be suspicious of diabetes, if that disease has not already been diagnosticated.

2. Calling to our aid the ophthalmoscope we penetrate beyond the lens, and in proportion to our skill in the use of this important instrument, do we find its value as an aid in diagnosis.

Now we have laid bare for our scrutiny arteries, veins, nerves, and nowhere else does Nature give us so close a look into her mechanism. We may fairly judge from the anæmia of the retinal vessels, the depraved condition of the general system; from their hyperæmia we look for excited action of the heart, and in passive congestion, fear mitral disease, emphysema, thrombosis, and the like. Frequently we see pulsation of the veins, often having no special significance, sometimes signifying increased intra-ocular tension; more rarely we view arterial pulsation, which may mean so serious a heart disease as aortic insufficiency. Faint arterial pulsation may also be seen in acute anæmia from hemorrhage, and more marked in glaucoma, in which disease, however, the throbbing is confined more to the disc, and is accompanied by the usual symptoms of cupping of the disc, shallowness of the anterior chamber, steadiness of the cornea, etc. Hemorrhages from the vessels are easily detected, and, according to their character, lead us to suspect leucocythæmia, pernicious anæmia, putrida hemorrhagica, scurvy, or hereditary conditions, or dyscrasia, which are capable of producing degenerative changes in the walls of the vessels.

Looking at the internal coats of the eye one may see such strong evidences of tuberculosis as the tubercles themselves, especially upon the choroid; and syphilis may register itself upon the retina and choroid in signs almost as distinct.

Rarely we may see in the eye some of the entozoa, the commonest being the *cysticercus cellulosæ*. The *echinococcus hydatid* may also develop there, as may numerous kinds of growths.

An important aid in the diagnosis of so serious a disease as Bright's disease is the condition of the retina, as seen by the ophthalmoscope; inflammation of this delicate structure may be developed in any form of this affection. Albuminuric retinitis most generally appears in the latter stage of Bright's disease, when the disease has been long recognized by the other signs, and yet it frequently happens that the ophthalmoscopist is the first to detect this malady.

Of late years the eyes and their appendages have been carefully studied, as being valuable indices of the condition of the nervous system. We readily appreciate how this may be when we consider that of the twelve pairs of cranial nerves one-half send branches to these organs, and the two, three, four and six pairs are distributed exclusively to them. In addition, the sympathetic system is well represented, and the blood and lymph circulations are closely connected with those of the cerebrum. Intra-cranial pressure is almost certain to be felt in the eyes, and inflammation of the optic nerve is nearly always the sequence of some growth in the cranium. Gowers thinks that in at least four-fifths of all cerebral tumors, optic neuritis occurs at some time. So when we see papillitis, or the so-called "choked disc," we are likely to find back of it some cause for pressure in the cranium; whether it be a tumor, syphilitic deposit, abscess, meningitis, hemorrhage, etc., is often a question for experts to decide. In the insane we frequently find marked disturbance of the pupils, and

of the muscles of the eyes; and locomotor ataxia and other like affections, due to lesions of the nerve centers, frequently present motor disorders.

Passing from these conditions, which indicate, and often so plainly, many serious diseases of the nervous system, we note some less definite ones which tell us of toxic poisoning by alcohol or tobacco. The slight œdema of the disc, with the accompanying tortuosity of the retinal veins, may not be so easily recognized, but the color scotomata, especially that for red, will assist us in connecting the amblyopia with the abuse of these narcotics. Many a slave to these habits has been induced to break off by the approaching blindness, after all other means have failed.

And now, having spoken, briefly and perhaps too indefinitely, of some diseases which register their signs in the eyes and their appendages, and may often be diagnosticated—or, at least, have their diagnoses made more complete—by means of a careful examination of these organs, I come to the last part of my paper, which I may outline as—what the ophthalmoscope tells us, that will often explain such symptoms as the following: headache, frontal, temporal, occipital, etc.; numerous disorders of digestion, sick headache, obscure nervous symptoms, dizziness, "car sickness," and occasionally chorea, and even epilepsy.

In order to limit myself to the allotted time, and yet impress you with the importance of this part of my theme, I will quote a typical case from my notebooks, and briefly comment upon it:

Mrs. C., a very spare brunette, mother of one child, aged ten (herself thirty-six), says she has suffered for sixteen years with almost constant headaches, coupled with dyspeptic symptoms, and pains in the back and sides. She is a woman of intellect, one whose life has been spent more among books than in the performing of household duties. She has undergone numerous treatments by physicians for catarrh, dyspepsia, "spine disease," uterine diseases, neuralgia, etc., and all with no result; the relief, indeed, being only to disappoint her, and thus increase her nervousness. At last, the ophthalmoscope is turned on her case with the following result: No abnormality noted save that it takes 0.50 dioptré more to focus the vessels in one meridian than in the opposite. Her distant vision, when tested without the use of a mydriatic, proves normal; her near vision ditto, only when the card is brought to the nearest limit of vision, she draws away and says that it makes her sick at the stomach. Here we have a low degree of astigmatism, which, as the woman insists, causes no defect in her vision; she knows it, because she reads a great deal, even at night, and in bed when she is too tired to sit up. Nevertheless, she was put under a mydriatic, and, with her accommodation fully suspended, her distant vision dropped but a trifle, to be again raised to normal, in the right eye, by a weak spherical lens (plus 0.25 D.), in combination with a slightly stronger cylindrical (plus 0.50 D., cyl. ax. 180), and in the left by a still weaker combination (plus 0.25 D., sph. 0, plus 0.25 D., cyl. ax. 135). The treatment was a pair of sphero cylinder lenses set in spectacles, and the outcome of it all: the relief of her headache and the subsequent disappearance of her other symptoms.

It may seem surprising that such a trifling error of refraction could set up so much trouble. Of course, the woman's occupation and the sensitive condition of her nervous system had much to do with it; the same amount in a South-Sea islander might not have bothered him at all; but in civilization, as a rule, small errors of this kind cause more distress than the

gross ones, and the reason is, that the muscles of accommodation, when they can overcome the loss of refractive power by making the lenses more convex, do so, and the eyes attain normal vision, but the possessor of such eyes works them under a stress which, according to the use made of them, may sooner or later bring about a train of symptoms which are not always limited to the eye, but, reflexly, affect many other parts of the body, and throw the physician off his guard in their treatment. A large amount of the same kind of error may mean more reduction of vision and less asthenopic symptoms, because the ciliary muscles, not being able to reach normal vision, do not strain themselves trying to do so. In these cases the patients, realizing the much lowered condition of their vision, seek glasses for the betterment of it, and get all the other relief into the bargain; while in cases of small errors, the sufferers are often treated for their symptoms, and the cause, being unrecognized, goes uncorrected.

Had I time to quote more cases I could show how even such intractable diseases as epilepsy are sometimes much benefited by correcting lenses; and I have the record of one case of irritable heart, which held out against all forms of treatment until a compound hyperopic astigmatism was discovered, and a pair of proper sphero-cylinders adjusted. I would also show how a so called dull and stupid child often has the rod misapplied at school, or how disappointment and sorrow are felt at home by the report that the child will not apply himself to study, when all the suffering and disinclination to study are caused by defective eyes, and what the misunderstood child wants is a pair of properly-fitted spectacles. But such things are fast becoming common knowledge, and soon we may have upon our statute books laws compelling all school children to have their eyes examined before beginning their course, just as vaccination is required now. Let us hope that, at the same time, a law will be enacted which will prevent the more than possible ruination of many eyes by incompetent traveling opticians.

I will conclude by merely mentioning several other indications the eye furnishes which are of value. In poisoning by such well-known drugs as belladonna, stramonium, hyoscyamus, cocaine, and strychnia, there is dilatation of the pupils, while the reverse obtains where the deadly drug is opium, or physostigma, or pilocarpin, etc.

In the administration of ether and chloroform, we should closely watch the pupils, whose enlarging should warn us of impending danger; a rapid dilatation in the use of the latter anæsthetic should call for a sudden halt in the proceedings.

LARVÆ OF DIPTERUS IN THE HUMAN INTESTINE.¹

By H. O. JEWETT, M.D.,
CORTLAND, N. Y.

MY attention was called about twelve months ago to the larvæ which form the subject of this paper. They were brought at nearly the same time, to Dr. Caleb Green and the writer, by two different patients living not far from three miles apart. One, a man of about thirty years, the other a young school girl, both intelligent, reliable persons, who, confident that they had discharged them from the bowels, were at first somewhat alarmed.

¹ Read before the New York State Medical Association, at New York, November 29, 1891.

The larvæ, of which we had seven or eight in all, were of different sizes, varying, in their fresh state, from seven to fifteen lines in length, resembling in form, but larger, more elongated and rather more tapering at the extremities than the larvæ of the common bott or gadfly. They appeared to be entire, with no distinct marks of segmentation, having rudimentary feet, or prolegs, and a tail about the size of a common knitting needle, evenly tapered and somewhat longer than the body of the worm.

Those brought to us immediately after they were believed to have been voided, were very active, and of a nearly white, very soon changing to a dark mud-color by exposure to the light and air.

The first and largest specimen, measuring one and one-quarter inches in length, was brought to me by the man—a carriage painter and repairer by trade, very fond of, and considerably accustomed to the care and management of horses.

This man lives in a new house, situated upon dry, gravelly soil, in a newly built-up part of the town, with clean, wholesome surroundings. He is a man of correct habits, ordinarily cleanly in his person, a good liver, and obtains his water for drinking and culinary purposes, from a driven well with twenty-five feet of pipe. Such a well as is in common use upon our flat lands—affording pure water, if not in too close proximity to marshes or cess-pools.

This patient has usually enjoyed fair, though not robust health, but had, for several weeks complained of a capricious appetite, some considerable irregularity of the bowels, with occasionally bloody stools, attended with severe spasmodic, gastric, and abdominal pains, and frequent, but transient nausea.

Believing, as many others do, that he had worms, he sometimes fancied he could feel them crawling in the lower bowels. For these symptoms he had occasionally taken a vermifuge composed of some mercurial with a few grains of santonin, with apparently no other result than the cathartic effect.

While at stool, one afternoon, feeling an unusual tickling sensation about the anus, he turned to look for the cause and discovered the larvæ partly imbedded in the freshly voided excrement. Confident, from its situation, as well as from his own sensations, that he had passed it, he put it in a small vial and brought it to my office.

On the following day I took it to Dr. Green for examination, and found that the doctor had just received one of the same description from the young lady.

The history of this last was as follows:

Dr. Green had treated the girl from time to time, for severe attacks of spasmodic gastralgia with nausea, frequent colicky pains in the lower part of the abdomen, and some nervous symptoms.

The mother, believing that the girl was "troubled with worms," gave her, in the course of a day, three doses of what was called "*Kickapoo Indian Worm Medicine*," a nostrum containing some cathartic properties. The next morning, before going to school, the girl had two evacuations from the bowels, using a clean, white, earthen vessel in her room. After defecating, curious to observe the effect of her vermifuge taken the day before, she examined the stool, saw the larvæ and reported to her mother who went at once to the vessel and inspected its contents, finding the worm squirming about as if annoyed by the urine present with the fæces.

She was struck with its peculiar appearance, its activity, and particularly with the tail, as she expressed it, "like that of a mouse." Naturally anxious

about the condition of her daughter, she put the worm in a small tin box, and sent the girl directly to Dr. Green with it.

We compared our specimens, found them identical, and our first impressions were that they were solitary, accidental entozoa; not such from preference, but by chance. But, upon subsequent search, several more were found among the ordure in a commode or closet used by the girl and some other members of the family.

This family, like the other, live in a healthy locality in the suburbs of the town. They are remarkably neat and tidy about their house and household affairs, are good wholesome livers, and obtain their water from a driven well more than thirty-five feet deep through loose, gravelly soil, and probably a stratum of clay several feet below the surface.

These wells, unlike the old-fashioned dug wells, admit no surface drainage, but afford, so far as known, pure water at all times.

Thus it will be seen that there is nothing about the surroundings, the habits or the diet of these people which apparently offers a clew to the origin of the parasites.

The above mentioned include all of this species of larvæ which we have seen, or heard of, in this or any other community. And it is evident that they must be rare to have so long eluded the general observation of, and received so little attention from expert entomologists.

Of course, we saw none of these things emerge from the rectum, nor could we be expected to furnish such positive evidence.

Neither could our patients have seen them discharged; but they aver that they felt them, and found them involved in the freshly voided excrement.

Had these all been brought to us by a hysterical girl, without corroborative evidence, we might have had some reason to suspect it as one of those freaks so common to that class of patients. But even then, they would have been a curiosity, leaving us to wonder how she could have obtained them in their obviously fresh condition.

But, to summarize the testimony, myself vouching for the credibility of the witnesses: We have an adult man and a young girl, living miles apart, strangers to each other, and neither one cognizant of the experience of the other. Yet they come to us, at about the same time, with separate accounts of a corresponding experience. There was no chance for collusion, and no good reason to distrust the sincerity of our patients.

It is scarcely possible that the man could have been mistaken when, prompted by his sensations, he turned immediately to examine his stool and saw the larvæ in the condition which he described.

Nor is it at all probable that the young lady would have failed to see the worm, by daylight, in the white vessel, had it been there beforehand; or that it could have reached there unobserved, during defecation, except by being voided with the stool.

I had observed that, while these creatures were quite lively in fluid or semi-fluid substance, they could make very little headway upon a smooth, hard surface; hence they could not have climbed the outside of the vessel, or reach any point above, so as to have fallen into it.

But circumstantial evidence is sometimes better than direct testimony, and, as significant circumstances, we have the previous condition of our patient, as observed by Dr. Green and myself. Their subjective symptoms justifying a diagnosis of vermi-

ous irritation, the appearance of the parasites soon after the administration of well-known anthelmintics, and we have the additional fact, that those patients have since remained entirely free from the harrassing symptoms complained of before.

It will also be remembered that those of the larvæ shown us immediately after they were supposed to have been voided, were of a pearly-white, suggesting an internal origin, whereas, had they been developed in any outside situation, they should have been of the dark color which they so soon assumed on exposure, and as were those found at a later period.

That these are, indeed, true entozoa, either from preference or by chance, and being expelled like other entozoa are afterwards discovered in the ordure, or, that they have a chosen habitat among, and a special affinity for, human excrement, must be apparent.

Recognizing the fact that many species of dipterus seek a place in loose earth and decomposing vegetable matter during the proper state, I have caused search to be made for traces of them in the decaying refuse of wood piles and stables, but, thus far, with entirely negative results.

Not desiring that you base your judgment upon our belief, I have been thus particular in detailing the facts bearing upon the probable origin and source of these larvæ, in order that you may form your conclusions independent of any conviction of our own in the matter.

I sent several of our specimens, by mail, to Dr. A. L. Carroll, of this city, and am indebted to the doctor's researches for the identification of them as the "Bat-tailed Larvæ" of a rare species of dipterus which, though not hitherto unknown, has received very little attention from scholars and writers upon the subject.

According to the doctor's authority, the tail, which is a distinguishing characteristic, is a respiratory organ, disappearing like that of the mosquito during the pupa stage, and giving place to quasi horns.

Whence these things come, and how they are introduced, are, as yet, matters of conjecture. But the ova, once ingested, the vitality of the embryo may resist the process of digestion; and, though they have no hooks by which to attach themselves to the mucous membrane, like bots, they may be able to maintain their occupancy of the alimentary canal for a season at least, during the larval growth.

It is not to be supposed that, in this larval state, they can multiply by propagation, or that they can maintain their tenancy beyond a definite and limited period; yet they are by no means desirable, even as temporary guests.

A few instances have been reported of the presence of bots in the stomachs of grooms; also of the well-known gadfly, the *oestrus bovis* and *oestrus ovis* respectively, beneath the skin, and in the frontal sinuses of man.

But, I am aware of no previous authoritative report of the "rat-tailed larvæ" having been discharged from the human intestines.

Questions of importance, in a sanitary as well as scientific point of view, are: To what particular species do these belong? What is their most natural habit? And where does the insect deposit her ova? Are they habitual or merely accidental parasites?

Other questions of importance to the physician are: How do they reach the human stomach? If, in food or drink, what food or drink is responsible for their introduction? Are they taken in meats, fruit, vegetables or water?

Their extreme activity, in all probability, rendering them more offensive and annoying than ordinary internal worms, how much mischief may they accomplish by their presence as entozoa?

What sanitary or dietetic precaution will most effectually prevent or dislodge them?

But, whatever their type or origin, whether they be harmless, earth-born denizens of the outer world, or unwelcome tenants of our interior, they are certainly of sufficient interest to invite the careful attention of physicians and naturalists.

Other members of this Association may have preceded me in the discovery of these curious larvæ, and it is for the purpose of stimulating inquiry and eliciting further information that I have brought the matter before you, with an exhibition of the specimens, to-day.

In addition to what I have said, Dr. Carroll will kindly give you the result of his researches in elucidation of the subject.

OBSTETRICS AND GYNECOLOGY.

By E. S. MCKEE, M.D.,
CINCINNATI, OHIO.

THE GYNECOLOGICAL USES OF ARISTOL, ICHTHYOL, IODIZED PHENOL, RESORCIN, CREOLIN, AND CHLORIDE OF ZINC, by Dr. C. D. Palmer, Cincinnati. The author has found aristol superior to iodol and iodoform. It is unirritating, non-absorbable, and has no toxic effect. It possesses stimulating, alterative, and anæsthetic properties. He uses it in the pure form, as a powder, applied by insufflation. In narrow passages it may be used by suppositories. It becomes an admirable dry dressing for some cases of chronic vaginitis, vulvar pruritis, cervical endometritis, cervical erosions and fissures, mammary fissures, and syphilis—primary and secondary. Aristol gauze can be made by impregnating plain gauze with an ethereal solution of aristol, containing from 1 to 2 grammes of aristol per yard. Crayons for the urethra or uterus can be prepared by using at least 1 gramme mixed with a sufficient quantity of gelatine or gum acacia.

Ichthyol appears to favor the healing processes, mitigating pain, and favoring the absorption of inflammatory exudates. Dr. Palmer has utilized ichthyol in three ways, giving it internally, applying it externally and topically to diseased structures. His experience so far has been rather favorable, but not enough so to justify an enthusiastic expression. He employs iodized phenol more frequently than any other medicament within the whole range of medical preparations, excepting Churchill's tincture. He uses it for chronic morbid conditions of the endometrium, with or without special functional disorders. He employs it by ingestion and injection, without, or following, curetting. The drug is antiseptic, alterative, astringent, mildly caustic, and hemostatic.

Resorcin has proven an admirable remedy, combined with boracic acid and white vaseline, or incorporated with the ointment of the oxide of zinc as a salve, to be applied to certain skin diseases of the external generative organs, and to foul-smelling, indolent ulcerations in the puerperal as well as gynecological conditions. Creolin is an efficient germicide, and in some respects is more powerful than carbolic acid, more destructive to the micro-organisms of various diseases, and of suppuration. It is less toxic than carbolic acid, but is not entirely void of toxicity. Chloride of zinc is valuable for vaginal and endometrial morbid conditions. All malignant dis-

eases of the uterus for any cause, rendering partial or complete hysterectomy unjustifiable, are signally improved in general health, given a prolonged life, and materially bettered in all local symptoms by a thorough application of the zinc chloride after sharp curetting. He has used intra-uterine tampons saturated with a solution (from 25 to 50 per cent. strong) or crayons, equally strong, a protection of the vaginal mucous membrane being maintained at the same time.

THE PREVENTION OF RETROVERSION OF THE UTERUS (A. Laphorn Smith, Montreal, *Journal of Gynecology*, September, 1891).—The sensitive uterus thumps down upon the sacrum, or, in some cases, pounds the imprisoned ovaries. If accoucheurs would adopt a few simple rules, all this suffering might be saved. First, to instruct patients not to lie on their backs, but to lie occasionally on their faces, and to turn freely from side to side. Allow them to sit up while taking meals, and to relieve bladder and bowels. Not to allow bladder distended the first few days, but order catheter passed every eight hours at least. Abandon use of obstetric binder until involution is complete and patient up, and uterus anteverted. To order the simplest case a daily douche of plain or medicated hot water, so that, if retroversion does occur, it may not be rendered hopelessly incurable by adhesions. To keep the bowels in an easily movable condition, so as to avoid forcing the uterus when retroverted still further into the hollow of the sacrum.

THE ADVANTAGES OF ELECTRICITY IN PELVIC INFLAMMATORY TROUBLES is thus summarized by Dr. Geo. F. Hulbert, of St. Louis. The value and position of electricity in the method advocated and that places the result as due to its use is dependent:

1. The fact that in all other conservative methods recovery is not the rule, be the means used, drugs, local treatment, or otherwise. Occasionally, through Nature's unaided efforts, recovery results with time; but these cases are exceptional. Simple aspiration has been tried and found wanting, except in a few cases.

2. Prompt and progressive improvement observed within the shortened time required, usually averaging from one to nine months, according to the severity of the case.

3. The uniformity of results, non-recovery being the exception.

The author states that over 100 cases of pelvic diseases in which the inflammation had extended to the pelvic peritoneum had been treated by electricity. Four cases of pyosalpinx had been relieved by this method. Five cases had been relieved by the discharge of pus from the tube through the uterus. The remaining cases treated were not those in which suppuration existed, but inflammatory conditions, involving the tissues from endocervix to pelvic peritoneum.

TUMORS OF THE DECIDUA (*Centralblatt für Gynecologie*, June 13, 1891).—Prof. Säger has collected a considerable number of cases of deciduoma. A perfectly innocent form exists which must not be mistaken for inflamed and degenerate relics of decidua left adherent to the uterine walls. Säger and Chiari have observed a malignant deciduoma which gives rise to metastases—a true sarcoma of the decidua, in fact. Foul discharge and hemorrhage follow delivery, and death occurs within six or seven months after symptoms of disease in the bones, lungs, and other organs. The metastatic deposits in

the lungs resemble decidua, bearing the characteristic cells.

In the discussion on Prof. Säger's paper (*Union Medicale*, June 2), Dr. Muller stated that he had seen a case where masses of decidua-like tissue were found in the uterus, and metastatic deposits developed in the vagina, abdomen, and nates.

AMENORRHOEA AND DYSMENORRHOEA (*Le Bulletin Medicale*).—Apiol, the active principle of the seed of parsley, is an oily amber-colored liquid, insoluble in water but soluble in alcohol, ether or chloroform. It is absolutely harmless in its physiological action, even in commencing pregnancy. A dose of 8 to 15 minims produces slight cerebral excitement, a feeling of well-being and a sensation of heat in the stomach. In doses of $\frac{1}{2}$ to 1 drachm it produces veritable intoxication, accompanied by vertigo.

THERAPEUTICS.—It appears to have an action on the uterus similar to the action which digitalis has on the heart. It regulates menstruation. Therefore it is useful in all the derangements of menstruation, viz.: amenorrhœa, dysmenorrhœa and metorrhagia, provided the disturbances be idiopathic. If, however, these diseases be due to organic affections then these organic affections must be directly treated.

As disorders of the menstruation are a common cause of sterility, apiol may be said to be a remedy for the latter disease.

In order that apiol may exercise its most powerful influence it should be administered just prior to the beginning of the menstrual flow.

CONSANGUINITY, CONCEPTION, AND MALFORMATIONS (*British Medical Journal*).—Has the condition of the male parent, when begetting, any distinct influence on the offspring? A case related by M. Gueniot, at the Paris Academie of Medicine, would seem to favor the theory that there is such an influence; but in this case consanguinity must also be taken into account. A woman married her nephew, a man three years younger than herself, and long addicted to absinthism and other forms of intemperance. She declared that he was always partially drunk when she admitted his embraces. Seven children were born of which only one survived, and several were deformed. The last child was of great size causing difficult labor. It was anencephalous, with six fingers on each hand, and six toes on each foot; the external genitals were absent. Two large serous cysts occupied the liver, and were the cause of the great bulk of the child. Considering how some of the most minute physical peculiarities and some of the most subtle mental characteristics are transmitted from father to child, it is not wonderful that the offspring may be influenced by the state of its size when impregnating the mother. The influence is probably indirect in a case like the above. No doubt absinthism and ordinary intemperance affect the nutrition of all cells and fluids, spermatic included. The nervous condition of the mother may be unfavorable under the circumstances. The share of consanguinity in this case is doubtful. Recent researches tend to show that unions of consanguinity may keep up or intensify disease and malformations already in the family, but there is no evidence that they cause new maladies and deformities.

MORPHINE IN PREGNANT, PARTURIENT, AND NURSING WOMEN (*Archives d'Obstetrique et de Gynecologie*, March, 1891). First gives the result of his studies to determine the effect upon the foetus when morphine has been administered to the mother. In one case 1,200 hypodermic injections of a 3 per cent. solution

of morphine had been taken during pregnancy, and in a later gestation 800 injections of the same strength. Before labor the foetus was quiet after the drug was given to the mother until its effect began to wear off, when foetal movements were very active. After birth the children manifested no signs of physical or intellectual ill development. Furst concludes from this and other observations that morphine does not endanger foetal life to so great an extent as has been thought. Used moderately it is not a dangerous drug for pregnant women.

Society Notes.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, November 25, 1891.

CLINICAL CONTRIBUTIONS TO BRAIN SURGERY.¹

WAS the subject of a paper by JOHN B. ROBERTS, M.D.

DISCUSSION.

DR. M. PRICE: I should like to ask a question, and that is in regard to the propriety of removing a clot in a case where the operation has been delayed for some time, and where, after trephining, it is found that the clot has become adherent, and where the attempt at its removal is followed by free bleeding. This operation presented itself in the case of a young man injured in an iron works, in Phoenixville, some two weeks ago. A small stove shovel was thrown at him, the handle striking and penetrating the skull. For the first day or two there were no symptoms of paralysis. Dr. Shoemaker was called to the case a week or so after the accident, and at once decided on operation, at which I assisted him. There was incomplete paralysis of the right side, and there had been some slight convulsive attacks. The trephine opening overlapped the clot and the depressed fragment of bone. As I have said, the clot was adherent, and the attempt at removal caused free bleeding. We allowed it to remain, thinking that this would do less harm than the violence necessary to remove it. So far, the result shows that we acted rightly, but what the final result will be I cannot say.

Some of you may recall two murder cases which occurred in 1873. They were both cases of penetrating wounds of the skull through the eyeball, produced by umbrellas. One was a man who, after the injury, came to the Fifth street dispensary, where I examined him. He then went to his home in Camden, where he died in a few days. The second case was that of a drunken woman, whom I saw four hours later. She was wounded by her husband in his attempt to ward off her blows. She was removed to the Pennsylvania Hospital, where she died.

DR. T. S. K. MORTON: I did not understand Dr. Laplace to state that any provision for drainage was made at the time of the first operation. That might possibly have warded off some of the consequences of the injury.

I should like to ask those present their views and experiences as to the results of operations for epilepsy. It has been my fortune to see a good many cases of epilepsy operated upon, not only where the malady originated in the brain, but in other ways, as from phimosia, contracted tendons, neuralgic testicle, etc., and in none of these cases, if my memory serves me

right, has there been a permanent cure. In one case, where a contracted tendo Achillis was divided, the seizures remained absent for two years, and then returned. It has seemed to me that possibly the profound anæsthesia has something to do with preventing the occurrence of the attacks.

I had one case of what was considered traumatic epilepsy referred to me by Dr. Mills, that of a child two years of age, who had fallen, striking its head on a piece of iron. Before the accident there had been no epileptic seizures; after the injury seizures soon began, and recurred with great frequency. A thousand convulsions were counted in a short time. These involved one side of the body, apparently beginning in the centers for the thumb, finger, and arm, extending down the right side, and subsequently becoming general. It was decided to apply a large trephine over the arm center, and see what was there. An inch-and-a-half button was taken out. The dura was thickened, and I dissected it entirely away, leaving a margin of an eighth of an inch all around the trephine opening, so that hemorrhage could be readily controlled. There being no apparent lesion of the brain, the oedematous pia mater was not opened. The button of bone was not replaced. The flaps were sutured, and catgut drain introduced. The drain was removed ten hours after the operation, when the dressings were found saturated with serum. The wound healed by primary union, and the child went home into the country on the tenth day. I understand that there has been no material improvement in his condition.

DR. CHARLES K. MILLS: I can recall ten or twelve of my own cases of epilepsy in which I have had operations performed, and I have been present at fifteen or twenty other operations, so that I have a personal experience of some twenty-five or thirty cases of operation for epilepsy. I have also paid a good deal of attention to the theoretical part of the subject. I am sorry to say that the results, in the majority of cases, have not been permanently good; but I do not feel altogether discouraged in regard to cranial and cerebral operations for cases of this character. There are reasons why these operations have not succeeded. Some are inherent to the condition, while others are dependent upon errors of diagnosis, while still others are dependent upon the fact that the convulsive habit has been induced by the long continuance of the condition.

I have had two cases of cortical excision. One of these will be reported by Dr. Keen in the coming number of the *American Journal of the Medical Sciences*. In this case a small tumor was found in the center of the trephine opening, which proved to be a sarcoma. A part of the cortex, an inch in diameter, was also removed. Although the patient improved after the operation, she is now practically no better than before the operation. It seems to me that in this case the brain and nervous system had been so influenced by the long-continued convulsions that they could not recover. The great difficulty in many of these cases is the late period at which the operation is performed. In nearly all cases of epilepsy, except those due to recent traumatism, the affection has existed for some time. And then there are secondary changes which cannot be removed by trephining.

I think that of all cases certain classes of hemorrhage present the greatest likelihood of benefit from operation. These are certain supra-dural and sub-dural hemorrhages, which can be pretty well localized. In the case of Dr. Price, I think that it would have been better to remove the clot as a whole;

¹ See page 495.

not, perhaps, by traction, but by a second trephine opening. In some cases these dural and sub-dural hemorrhages do lead to permanent epilepsy, even though at first no symptoms are present.

I believe that the most brilliant results, although we have not had them yet, will be in cases of brain tumor. In this class of cases, fibromata offer more chance than any other forms of growths, for, usually, they do not permeate the brain. Some old syphilitic tumors, and a few of other varieties, can be removed. The difficulty in these tumor cases is that they have been left too long.

DR. JAMES HENDRIE LLOYD: The cause of the paralysis of the arm on the same side as the tumor in this case seems obscure, but I inferred from what Dr. Roberts said that he was not himself certain of the accuracy of this observation. I can hardly see how that tumor could cause hemiplegia of the same side, unless it acted as a cerebellar tumor sometimes acts—by downward pressure. In some tumors of the cerebellum there is hemiplegia on the same side from pressure downward on the motor tracts below their decussation. In this case the tentorium would probably prevent such downward pressure, and I hardly see how the alleged fact could be explained in this way. The brain has not been thoroughly dissected, and there may be some other lesion, as hemorrhage or a secondary growth, which has caused this symptom.

DR. ROBERTS: I was much interested in Dr. Laplace's case, but I do not quite understand the condition of affairs. I understood that the temperature, which had been high, had descended to about normal before the operation. I should like to know what was the character of the clot some two weeks after the accident. Was it broken down or partially organized? It seems to me that it would be difficult to get away an old clot of blood, which would be fibrinous, from such an irregular surface as the base of the skull. I could not help thinking that possibly the clot removed was one due to the manipulations at the base of the brain. Again, was the discharge from the wound serum from blood-clot, or was it cerebro-spinal fluid mixed with a certain amount of inflammatory exudate? While the result has been exceedingly brilliant, I could not help thinking that perhaps if no operation had been done the patient might still have recovered. As the history, as I remember it, seemed to indicate beginning improvement, was it absolutely necessary to keep the wound open for a number of days? I can understand that drainage is necessary in recent brain injuries, but in this case the drain was used at a late period and kept up for some time. The case is one of extraordinary interest, and I simply wish to have these points brought out clearly, as I failed to grasp the points when the report was read. No unjust criticism is intended, but I wish to study the case.

It seems curious that in my specimen of brain tumor there should be right-sided hemiplegia, but I think that there is little question that it was on the right side. I inquired in regard to eyesight, and, as far as known, there was no blindness or deafness. Very few symptoms were noted, as the patient was in a public institution and made no complaint until a few days before her death. I would have been interested to hear in regard to the probability of the paralysis being due to pressure upon the longitudinal sinus damming back the blood and making secondary pressure, as it were, on the opposite side.

DR. LAPLACE: I would state in reply to Dr. Morton's question, that at the first dressing I put in an

iodoform drain, which remained in until the time of the operation.

In regard to the points suggested by Dr. Roberts, I would say that I was well aware that on the thirteenth day the clot would not be in the condition that it was on the second day. I knew that it would be fibrinous, and, in order to entangle it, I devised the little instrument shown.

A few hours after the accident the temperature rose to 104° , and then for the next ten or twelve days varied between 100° to 103° . The coma then began to increase. Because the temperature before the operation was low, it did not follow that the patient was getting well. The patient was really worse. He was more comatose and he could not swallow. He had to be nourished by the bowel. Something had to be done, or he would die. I relieved the intracranial tension and provided for drainage. There must be drainage in cerebral surgery on account of the unyielding nature of the cranial wall.

MODIFIED JUNKER INHALER, WITH POINTS FOR DISCUSSION ON ETHER AND CHLOROFORM NARCOSIS.¹

Was the title of a paper by MARIE B. WERNER, M.D.

DISCUSSION.

DR. JOSEPH HOFFMAN: I have used this instrument quite a great deal, and its utility for chloroform inhalation is unquestioned. The quantity of chloroform required is much diminished by its use; for an extended abdominal operation I have more than once had a drachm of chloroform suffice. Nor have I seen any bad effects from chloroform when this instrument was used, although I do not believe that the bad effects are completely obviated. In two or three cases I have found that ether had to be abandoned and chloroform substituted.

So far as the report of the Hyderabad Commission is concerned, I do not think that in this country it will be accepted as final. The results of experiments on animals are not always applicable to man. In the sudden deaths in man, fatal result is brought about by action of the anæsthetic on the heart, and not on the respiratory apparatus. Chloroform paralyzes reflex action, while ether stimulates it. In children there is little danger from chloroform, and in children too the reflexes are stronger than in adults.

So far as the application of this apparatus to the administration of ether is concerned, I do not think that it will work, as it is not possible to obtain a dense vapor of ether in sufficient quantity. If the apparatus were modified so that a large quantity of vapor might be produced, the effect might be better. Finally, too, it is to be insisted, that to obtain good results and to escape the dangers of anæsthesia, we must depend rather on the anæsthetizer than in any apparatus he uses.

DR. JAMES COLLINS: I recall very well the time when we had no ether. It was chloroform. Chloroform was found in all the medical chests and was given with impunity. We never thought of danger, provided the man was sufficiently recovered from shock. I saw only one accident from chloroform, and that was after the battle of the Wilderness. We had been giving chloroform all day, when a man came in with a wound of the hand; he took a few whiffs of chloroform, and expired. In his case the rule had not been observed—that is, not to give the anæsthetic when the man was under the influence of shock.

¹ See page 502.

The shock from gunshot wounds often acted strangely. Men with severe wounds would walk long distances to the hospital with no sign of shock, and yet, when placed in bed would, in a few minutes, present marked evidences of shock. It was with some regret that I saw the reaction against chloroform that came later. Chloroform is certainly more pleasant than ether, and I think that if properly given it is as safe as ether. I have seen death from ether. It was a case of pistol-shot wound; ether was given and the shock came on while the man was under the influence of the anæsthetic, and he died. Many years ago, at the University, we gave a mixture of ether and chloroform. From that, I saw no accidents.

DR. JOSEPH LEIDY: The only death that I have seen from an anæsthetic occurred while chloroform was being administered with this apparatus. The chloroform was administered by a gentleman who had been in the habit of using this instrument almost daily for months. I think, however, the death would have occurred whether the instrument had been used or not.

DR. JOHN B. ROBERTS: I have seen six deaths attributed, and probably justly, to anæsthetics. Fortunately, in none of these was I the administrator of the anæsthetic. I never had a patient etherized without feeling a great deal of discomfort, especially if the ether is given by the ordinary individual that administers ether. The majority of them do not know how to give ether unless they have seen a death, or nearly killed some one by ether. If ether or chloroform is given 100,000 times without a death, it is no proof that there is no danger in the administration of ether or chloroform. Although the Hyderabad Commission decided that chloroform is better than ether, yet I think that Dr. Wood echoes the sentiment of this portion of the country, at least, when he says that ether is the safer.

It seems to me that the difficulty is that the anæsthetic is placed in the hands of incompetent people, who do not know how to give it and do not pay attention to their work. In several of the cases of death from anæsthesia which I have seen, I believe that the result was due to the carelessness of the administrator. A short time ago, I saw a patient nearly die from ether, and he was only kept alive by about an hour and a quarter's artificial respiration. The trouble in this instance was due to the fact that I, the operator, called the attention of the anæsthetizer from his work. I have scarcely used chloroform, and have seen very little of its use, but, if the evidence of literature is worth anything, it is in favor of ether. I do not believe that it is the shock of injury; I believe that it is the chloroform that kills. Chloroform is certainly the more powerful and more dangerous agent. In spite of the objections to ether, it seems to me that the opinion of the Philadelphia profession in favor of ether is correct, and is borne out by the literary evidence.

DR. T. S. K. MORTON: I have had an opportunity of examining this apparatus, and so far as apparatus goes, it seems superior to any that I have seen. But I do not see that any method for administering chloroform can be better than the little wire frame, invented, I think, by Esmarch. So far as ether is concerned, I dispense with all apparatus; especially do I dislike the Clover apparatus, where the patient respire the same air over and over. In most cases, ether is given badly. Just as I have learned to give ether in less condensed form, so have my results been more satisfactory. The cone, as usually employed, is extremely objectionable; and towels, as

found at patient's houses, are usually impregnated with starch, and will not absorb the ether or allow air to pass freely through. Unless you obtain very old towels or napkins, it is either difficult to etherize the patient, or you have to give the ether in too concentrated form. Some two or three years ago, it struck me that it would be well to use cheese-cloth for this purpose, and since then, I have used nothing else. I use small squares, about six by seven inches, consisting of ten or twelve thicknesses of the gauze. This is placed over the patient's face and the center raised up by puckering the lateral edges. This offers no obstruction to the passage of air. The ether is dropped upon the center of the gauze from above. I have etherized a child by this method, and kept it under the influence of the anæsthetic for ten minutes, with but one dram of ether.

DR. WERNER: In presenting this apparatus, I did not wish to be understood as advocating the general use of chloroform. It seems that there are some cases in which it can be used with better advantage than ether, and, therefore, it is well to know the best method of administering it. I think that the trial alluded to by Dr. Hoffman with this apparatus for ether was not a fair test. The patient was difficult to etherize at best, and seeing that, I used the towel. I had occasion to try it again for a smaller operation, and it answered admirably. In answer to Dr. Morton's remark about the unequal supply of vapor and air, I would like to call attention to the fact that this stopcock, if adjusted properly, will give a continuous current of air. I think Dr. Morton's plan of giving ether better than the towel. I heartily indorse Dr. Robert's statement that there is often not sufficient care and attention given by the anæsthetizer to the work in question, and can feel certain the operator can work with greater freedom when the mind is at rest in that direction. I think there is room for improvement in the methods of administering both ether and chloroform.

The Polyclinic.

PHILADELPHIA HOSPITAL.

(Service of Dr. Roland G. Curtin.)

A CASE OF LATENT RHEUMATIC ENDOCARDITIS.

THE patient whom I present to you to day is one of unusual interest. His history is as follows: He has been following the occupation of a stevedore, and after exposure to wet, he began to complain of feverishness and pain in his joints, which soon began to swell. Before admission to the hospital he was confined to bed for several days. Since his reception into the hospital he has had a constant elevation of temperature. His right knee and left ankle have been hot, swollen, and painful. I carefully examined his heart, and found the sounds perfectly normal.

One week later (two days ago), I listened again to the cardiac sounds, and found a prolongation of the first sound over the mitral area. To-day I find a still greater change at the same place, the change amounting to a slight murmur. Now this sign has crept in without any of the usual symptoms of endocarditis, such as increase in the temperature, dyspnoea, pain in the chest, or throbbing of the arteries, or any tumultuous action of the heart. These are the symptoms which are usually associated with acute endocardial trouble, occurring in the course of an attack of rheumatic fever. In this particular case the disease has

crept in without a single symptom, and with but one physical sign, namely, prolongation of the first sound over the mitral area. Dr. A. Ernest Sansom, in his Lettsomian lectures, calls attention to this early physical sign as an important evidence of endocardial inflammation. Without this physical sign, I would not have suspected any inflammation in the endocardium. You should be careful frequently to examine the heart in rheumatic fever, for early treatment may prevent very serious heart trouble. The case teaches us another lesson. In after years this man may be asked whether he has ever had rheumatic fever; and further interrogation as to whether he had, during the attack, any pain in his chest, shortness of breath, and palpitation, would bring from him an answer in the negative. To-day I find that there is a little increase in the temperature, and the pulse is slightly increased in frequency. The probability is that this new inflammatory condition at the mitral valve has been the cause of these slight changes occurring two days or more after the local trouble began. Dr. Van Gasken has taken four pulse tracings of the radial artery. They are all of the same character, indicating that the heart is performing its functions properly, notwithstanding the slight trouble at the mitral valve.

What should be the treatment in a case of this kind?

The treatment is of two kinds, general and local.

The general treatment he has been under since he has been in the hospital. When he was first admitted he was placed upon five grains of salicylate of soda four times a day. This remedy I would caution you against using for too long a period. You obtain all the good effects possible from this remedy in about four days. It should be then discontinued.

After this he was placed upon an alkaline treatment, consisting of acetate of potassa, sweet spirits of nitre, and liquor potassa citratis. The sweet spirits of nitre was put in the mixture to aid in the elimination of the irritant from the blood, which causes the fever and inflammation. The local treatment is principally counter irritation. First, a strong mustard plaster, followed on the second day by a good large blister over the cardiac region. Later on, the general treatment will be full doses of iodide of potassium. This has a two-fold effect after the first active symptoms:

1. It is an anti rheumatic.

2. It will have a beneficial effect upon the inflammatory deposits, hastening their absorption and cure. In convalescence from acute articular rheumatism, wine of colchicum root is beneficial, and also in cases of sub-acute rheumatism. In the acute stage it has no perceptible effect. What direction shall we give our patient when he leaves the hospital? He should not follow an occupation which will expose him to cold and dampness, for he might bring on another attack of rheumatism, which might prove fatal, through his already damaged heart. He should avoid an occupation calling for great activity or heavy labor. His heart will be unable to cope with such work. He will be left with an alteration in the cardiac valves which will call for increased strength of the left ventricle, which will in time become hypertrophied, in order to enable the crippled heart properly to perform its functions. As the man grows old, and the infirmities of life increase, he will be subjected to new dangers. The principal one is fatty degeneration. This will weaken the muscular tissue of the heart, for, instead of muscular fiber, we will have simply a row of fat globules. As this change goes on the heart will become weaker and weaker, until symptoms of heart failure gradually present themselves.

The blood is slowed, cyanosis, dyspnoea, palpitation, dropsy, creep in and generally end the scene. This is the history of the end of most of these cases. Sometimes life is ended by the patient succumbing to acute illnesses, the weakened heart being the cause of the fatal termination.

NURSERY POWDER.—To cure severe chafing or intertrigo, use:

R.—Camphoræ..... 3ij.
Acid carbolic..... gtt. xv.
Creta precip. (English)..... 3ij.
Zinci oxidi, pulv..... 3ij.
Oil nerolli..... gtt. v.
Oil rosæ..... gtt. ij.

M.—Rub the camphor to a fine powder in a mortar, using alcohol to reduce it, and mix the other components thoroughly; sift through bolting cloth of one hundred meshes to the inch.

INTERMITTENT FEVER.—W. R. D. Blackwood, M.D., Philadelphia:

R.—Quinia sulph.,
Cinchonidia sulph..... āā gr. cxx.
Ext. cannabis ind.,
Ext. belladonna..... āā gr. xv.
Piperine..... gr. xxx.
Acid arsenious..... gr. iij.

M.—Et in pil. No. 60. div.

Sig. One four times a day.

PRURITUS.—Dr. Brubaker recommends the use of the following preparation for pruritus:

R.—Acid hydrocyanic, dilut.... ʒij.
Sodii borat..... ʒj.
Aque rosæ..... ʒviiij.

M.—Sig. Use as a lotion.

TURPENTINE IN POST PARTUM HEMORRHAGES.—When ordinary means have failed a piece of linen saturated in turpentine, introduced into the uterine cavity and compressed against its walls, excites contraction of the womb and instant arrest of the bleeding.—*Ex.*

ECZEMA.—Unna recommends the following application for the relief of obstinate eczema of the scrotum and anus:

R.—Iodoformi..... ʒii-iv,
Zinci oxidi..... ʒiss.
Aq. calcis,
Ol. lini..... āā ʒiss.

M.—Sig. For external use.

—*Med. Record.*

CHARLES H. MERZ, M.D. (Med. Age), describes a case of successful trephining for traumatic epilepsy. The patient, now eighteen years old, when a boy of eight was kicked by a horse. He lay comatose for ten days, but gradually recovered with considerable loss of mental power and change in disposition for the worse. About a year before the operation, he began to have epileptic attacks, which gradually became more frequent. The surgeon found a depressed fracture near the posterior superior angle of the left parietal bone. Two disks of depressed bone three-fourths of an inch apart, an inch in diameter, were removed with the intervening bone. The wound healed without any unpleasant symptoms, and up to the time of reporting, eight weeks after the operation, the patient was free from attack.

The Times and Register

A Weekly Journal of Medicine and Surgery.

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THE REFLEX CLUB.

THE annual meeting of this able and progressive body lately took place. The proceedings were all of much interest, but especially so was that portion which related to the patient who appeared before the Association last year.

It will be remembered that the patient referred to was a woman of some thirty years of age, mother of three healthy children. She was a woman in the middle walk of life, wife of an artisan, of well-proportioned figure, and apparently in good health and strength, both mentally and bodily. She was, however afflicted at irregular intervals with severe headaches, and it was for this trouble that one of the members, who had failed to relieve her, brought her before the Club for diagnosis and suggestions as to treatment. Here the trouble began. All agreed without dissension, or, indeed, without examination of her head, that the pain was of reflex origin, but no two of the learned gentlemen could agree as to seat of irritation. Each member, as we might expect, traced it to that portion of the body with the diseases of which he was especially familiar. The discussion finally grew so warm that some of the members were forgetful enough of the dignity of the proceedings to exchange unpleasant personalities. This conduct was promptly checked by the president, however, who proposed as a compromise a plan that was immediately accepted. It was this: The patient was to be treated by each member in turn, according to his own diagnosis, the successive treatments to continue until either the headache or the patient should disappear. The order of members was decided by lot, and the first lot fell to Dr. Fallopius. This distinguished gynecologist had at once taken the patient to his private hospital, where she might have the best hygienic conditions. He had of course maintained that the headache was entirely due to reflex irritation from uterine or ovarian trouble, adding in support of his claim many similar cases which

he had cured by proper treatment of the affected organs. A careful bi-manual examination showed the uterus and ovaries to be of natural size, and in their normal positions. There was no undue tenderness of either of these organs or of the neighboring viscera. Her menses, as well as her bowels, were regular.

Not finding the trouble in this manner he decided on an exploratory incision, trusting he might then find the cause that had thus far eluded him. An additional motive in operating was the desire he had to reach an even two hundred abdominal sections before a certain date. He was compelled to acknowledge to the Club, however, that even his critical and experienced eye was unable to detect anything abnormal, either in tubes or ovaries. But as he had gone thus far, he had concluded it best to remove these organs, as the woman would thus be assured freedom from the danger of cystic ovaries or pyosalpinx for the remainder of her life, and he had accordingly done this.

The woman had next been taken in charge by Dr. Strabismus, of New York, who had strenuously maintained that the headache was a reflex irritation of the fifth pair of nerves, due to ocular strain, and had suggested muscle cutting as the remedy. A careful test of her refraction showing her to be emmetropic, he at once proceeded to relieve the headache in the way he had mapped out. The external and the superior recti were divided and set slightly forward, whilst the internal and the inferior recti were moved a corresponding distance backward. The superior and the inferior obliques had their attachments so altered as to rotate the eye a little outwards on its horizontal axis. Both eyes were treated in the same way. Despite his labor, however, the headache had still continued, and, although the eminent ophthalmologist insisted that the alteration in her optical axes simply gave the woman a coy and roguish look, others, not in sympathy with his methods, hinted rather broadly that, to their eyes, the patient was disfigured by a double squint upwards and outwards, whilst, in addition, she was burdened by a constant expression commonly known as "sheep's eyes."

Dr. Caustic, who had agreed with the last gentleman in assigning the pain to reflex irritation of the fifth, had received the third lot. But, being a throat and nose specialist, he had looked there for the mischief, and had found it. In maintaining his contention before the club, he had instanced many cases of headache in patients whose nasal cavities exhibited not as much abnormality as he found here, and who had been cured by treatment directed to the proper organ.

After removing, with the galvanic snare, several small polypi, the size of split peas, from the roof of the left narium, he applied the same instrument to a slight hypertrophy of the right middle turbinated. The septum being somewhat deviated toward the left, he perforated it with three different figures of the nasal punch, and forced the septum toward the median line by means of graduated bougies. He had also snipped off a piece of the uvula. This little operation he could hardly say was necessary;

but his new invention for this purpose, which he now had the pleasure of showing to the Club, performed the operation so quickly and neatly that he felt no defense of his action called for.

As the headache still persisted after these measures, he was forced to explain it by some trouble in the frontal or sphenoidal sinuses—places that he could not reach.

By this time the woman had grown so weary of operative treatment that she declared had she known what was going to happen to her, not one of them should have touched her; but, for a consideration, was finally persuaded by Dr. Pedibus, the well-known orthopædic surgeon, to submit herself to his treatment.

After finding that her right leg was one millimeter shorter than the left, he had traced her headache at the previous meeting to spinal irritation, the result of asymmetry. He now remedied the asymmetrical condition by having an extra sole put on the right shoe, of the required thickness; and, finding in addition, that smart, or, rather, heavy, blows on the right bended knee produced slight pain in the hip-joint, he suspected trouble there. He accordingly applied counter-irritation, in the shape of the actual cautery, at five different points, and was debating the advisability of dividing a muscle or two, when the woman vowed he should not come within ten feet of her with another instrument.

Dr. Rectus, of Chicago, had the greatest difficulty to persuade the patient to yield herself to his treatment. She had grown wary and suspicious of the whole Club; but his eloquence finally prevailed.

He had handled the theories of the other gentlemen with great freedom and considerable sarcasm at the previous meeting, demonstrating, at least to his own satisfaction, that a diseased condition of certain pockets in the rectal mucous membrane was the cause of all the trouble. As soon as the woman had entered his hospital he promptly etherized her, dilated the sphincter ani, inserted a probe into the offending pockets successively, and dissected out fifteen of them—all he could find.

Unfortunately, his dilatation of the sphincter had been so severe that the muscle proved to be permanently paralyzed, and the woman has consequently since suffered from incontinence of the feces.

This mishap capped the climax. She was so irritated that no persuasion could prevail on her to allow another member of the Club to treat her, although a number of the gentlemen were thus deprived of putting their theories to a practical test.

N. B.—Since writing the above, we have learned that an ordinary country practitioner suggested that the woman might have rheumatism of the scalp; although a similar suggestion last year provoked much merriment among the Reflex Club. However, the physician alluded to treated her for this affection, and the headache promptly disappeared.

E. B. SANGREE.

THE next International Medical Congress is to be held at Rome, 1893, and preparations for it are already engaging the Italian professional minds.

Annotations.

THE *New Nation*, Bellamy's paper, says that no society can be called rational, in which it is possible for a baby to inherit \$150,000,000, for the mere trouble of being born. This is apropos of the latest Astor scion, a family that bids fair, in conjunction with the Vanderbilts, to buy up the world in the course of time, and fence the rest of us out.

C. H. MOORE, M. D., of Columbus, notes an interesting case of quinine idiosyncrasy. A woman was found by him, three hours after taking a five-grain dose of quinine, lying as if dead. Pulse could not be detected at wrist, and heart beat very faint and slow. Eyes wide open and glassy, pupils dilated. She recovered in half an hour by the exhibition of brandy and belladonna.

THE *London Lancet* in discussing the subject of life insurance and the medical profession, complains of the maze of figures in which insurance companies usually conceal the bonus promised.

We can sympathize with any one who has tried to comprehend an insurance company promises from the study of its figures. As our contemporary says, "None but an actuary can do it."

This mystery, probably, is of service to the companies, else they would show the applicant figures that are intelligible.

A number of the English insurance companies have made a concession to medical men in the shape of a rebate of the ordinary commission, in case the applicant applies directly to the office.

AN OPENING FOR AN ENTERPRISING PHYSICIAN.

Through the kindness and wise discernment of Postmaster Zumstein we have received the following postal card:

"To Any Reliable Dr.
City.

Cincinnati, Nov. 22, 1891.

To Any Dr. that wants to put a good salve on the market I v the Best that can Be Put on the market and can be Sold on a guarantee it is good for Man or Best can be put up at the cost of 10 cts on the Dollar I havent the money to put it on the market if you want anything of the kind pleas address me at —E 5th st city, J. H."

We think it but proper that our readers should receive the benefit of this munificent offer, by which the thorny path of affluence may be robbed of its prickly terrors; and if any of them feel disposed to accept of his generosity, we will cheerfully supply the missing links in address and name, which for the present we withhold out of consideration for the natural modesty, and desire to avoid the publicity of the press, which the nature of the offer and the manner in which it is made known would indicate in the writer.

—Cincinnati Lancet Clinic.

WE have no doubt, that if some enterprising doctor will simply swear that the words of the salve maker are true, putting his oath into a little better English, he will reap his reward, provided, he advertises enough.

PREPARING FOR A VOYAGE.

THERAPEUTICS having thus far failed to give immunity from sea-sickness, or afford the sufferer relief, mechanics steps in. A. G. Greenhill offers a suggestion that may prove of some use. He advises a sort of acclimatization. In short, he advocates the manufacture of a full-sized ship section,

which is so arranged that it may sway back and forth and from side to side, after the manner of *bona fide* vessels on the briny and unstable deep. It is his intention that prospective passengers should drill themselves for an hour or two each day, for a short time, before venturing aboard, believing that they may thus grow so accustomed to the motion as not to be at least very much affected when they finally commit themselves. He urges that people would be likely to avail themselves of this plan because there would always be the comfortable thought that if things grew too unbearable, they could descend at will to the solid ground beneath, a thought, alas! far, far from the wave-tossed wretch on the mighty deep.

Letter to the Editor.

POISONING BY BUCKEYE.

A COLORED GIRL, aged two and a half years, ate an unknown quantity of black buckeye. "A large quantity of grease was given to her," and immediately afterward lockjaw set in. Powdered ipecac and a feather pushed down her throat failed to empty the stomach. There was no vomiting. Child was apparently unconscious; respiration slow. Salt and water was injected into bowels; ether into arm. Chest was rubbed with turpentine, and artificial respiration kept up without any result, except prolonging the death struggle. Child lived about two hours.

C. H. DONNELLY, M.D.

UTOPIA, UVALDE COUNTY, TEXAS.

Book Notices.

MANUAL OF PHYSICAL DIAGNOSIS. By JAMES TYSON, M.D. pp. 133; 17 illustrations. Philadelphia: P. Blakiston, Son & Co., 1891.

The work presents, in a clear but concise form, the teachings of the day on this important branch of medicine. The author follows, in the main, the teachings of Flint, although due recognition is awarded to later works on the subject. Gerhardt's change of note, illustrating the shape of cavities, is clearly noted in a few words. In the chapter on heart murmurs, the term "inorganic" is properly objected to as misleading, and "functional" or "accidental" is used instead. Students will find this work particularly useful in their early studies in physical examination.

HISTORY OF CIRCUMCISION FROM THE EARLIEST TIMES TO THE PRESENT; Moral and Physical Reasons for its Performance, with a History of Eunuchism, Hermaphroditism, etc., and of the Different Operations Practised upon the Prepuce. By P. C. REMONDINO, M.D. Philadelphia and London: F. A. Davis, Publisher, 1891. Price: cloth, \$1.25, net; paper, 50 cents, net.

We have read this book with much pleasure. The author has a breezy and interesting way of writing, that amuses while it instructs. He has gone to great pains to discover everything of interest with relation to the performance of circumcision, both historical, religious, hygienic, and, more strictly medical, making a strong plea for the more general sacrifice of an unnecessary and frequently hurtful appendage. He believes that the prepuce was probably of good service to prehistoric man, in protecting the glans from injury, when our ancestors were howling naked savages, and had quickly to shin up a rough-barked tree

to escape the engulfing jaw of some huge carnivora, or anon, as he sat on his haunches on some sun-baked sand-hill, whilst ants, gnats, and other annoying insects, crawled over his hairy skin. Those days having, happily, gone by, he thinks that the usefulness of the prepuce, along with that of the vermiform appendix, the plantaris, the muscles of the ear and nose, has also passed away, and that it should no longer encumber the ground—we mean the glans.

The Medical Digest.

J. HUGGINS, M.D. (*Alabama Med. Age*), relates three cases of tetanus successfully treated by large doses of gelsemium, and four others by the following method: A warm mush poultice, made of a decoction of red oak bark, and large enough to wrap the patient in from head to heels, was the only medicine. He was kept in this until recovery took place.

J. B. MATTISON, M.D., in a paper read before the County of Kings Medical Society, makes a strong plea for the more general use of *cannabis indica*, a drug that has rather fallen into disuse. His experience has been mainly with opium habitués, in the treatment of whom he has found *cannabis indica* most admirable. He says:

My experience with hemp covers more than a decade, many cases, and several pounds of fluid extract. It is proper to state that these cases have been solely habitués or ex-habitués of opium, chloral of cocaine. In these, often, it has proved an efficient substitute for the poppy. Its powers in this regard has sometimes surprised me. Both sexes took it, and with some no other drug anodyne was used. One of these—a naval surgeon, nine years a 10 grain daily subcutaneous morphine taker—recovered with less than a dozen doses. My oldest female patient—sixty-four—found its service complete. Its action has varied, as some cases respond more fully. This during the early abstinence time. Later, it has done good in the post-poppy neuralgia, especially the cranial kind, and it has calmed mental pain and unrest.

In some diseases common to women hemp works well. Grailly Hewitt says that in many cases of uterine cancer it allays or prevents pain. Ringer asserts it sometimes signally useful in dysmenorrhœa. West commends it here. Potter states that its anodyne power is marked in chronic metritis and dysmenorrhœa; and Hare thinks it of great value in chronic uterine irritation and nervous spasmodic dysmenorrhœa. Donavan and Fuller claim it of value in migraine and chronic rheumatism; and Mackenzie in hay fever and hay asthma.

In genito-urinary disorder it often acts kindly—the renal pain of Bright's disease; in vesical spasm; retention of urine, and chordee; and it calms the pain of clap equal to sandal or copaiva, and is less unpleasant. The distress of gastric ulcer and gastrodynia are eased by it, and in other and varied neuralgias it serves one well. In some cases of advanced phthisis and other cureless disease it will bring euthanasia by allaying pain and unrest.

Another cause of failure is too timid giving. I am convinced that the dose of books is often too small. The only true way is, once a good extract, push it to full effect. My doses have been large—40 to 60 minims of the fluid extract—overlarge for the non-narcotic habitué; but, as we years ago asserted, habitual poppy taking begets a peculiar tolerance of

other nervines, and they must be more robustly given. Both sexes have taken them—women frequently—with no other effect than quiet and sleep. I think, for many, small doses are stimulant and exciting; large ones, sedative and quieting. They are the outcome of an experience with smaller doses that failed of effect desired. They prove hemp harmless, and they add proof to the opinion of most neurologists that, once a nervine needed, it is often better to give one full dose than several small.

I close this paper by again asking attention to the need of giving hemp in migraine. Were its use limited to this alone, its worth, direct and indirect, would be greater than most imagine. Bear in mind the bane of American women is headache. Recollect that hemp eases pain without disturbing stomach and secretions so often as opium, and that competent men think it not only calmativ, but curative. Above all, remember the close genetic relation of migraine relieved by opium, to a disease that spares neither sex, state, nor condition.

Medical News and Miscellany.

PROFESSOR V. HIPPEL, Koenigsburg, has lately reported a successful case of cornea transplantation, a clear cornea resulting.

PROFESSOR REYER, of Gratz, who was formerly surgeon to the Viceroy of Egypt, and whose name is known principally by his surgical treatment of elephantiasis, has lately died.

AN ordinance has recently gone into effect in Berlin which will give the right of way to carriages of physicians driving through crowded streets. In order to distinguish doctors' carriages from others, the coachmen will wear white hats.—*Med. Age.*

THE Emperor of Germany has, lately, undertaken to purify his empire from sexual vice. As there are said to be some 50,000 prostitutes in Berlin alone, the Emperor would probably have found it an easier task to clean the Augean stables; but we wish him success.

A NEW DIGESTIVE FERMENT.—We heard a story on the physician in the south part of this State in regard to the use of Phillips' digestible coco. A traveling man for the coco house visited him and unrolled his tale of woe about the coco, when the doctor broke in on him and said: "See here, now, I have tried your digestible coco, and find that it won't digest anything, and have gone back to old pepsin again."—*Meyers Bros. Druggist.*

A LARGE portion of these advertisements (news-paper ones) are grossly indecent; they thrive on ignorance, and appeal to the immoral and depraved instinct of humanity. I refer to the nasty "female regulator," "errors of youth" and "lost manhood restored" advertisements that fill the papers. But all of them, whatever their appeals, whether to the frailties or infirmities of the reader, seek to divert the demand that must always exist so long as there are diseases, from the legitimate source of supply. They are pirates, robbing both the public and the druggists; the former by deceiving them into paying enormous prices for cheap things, and the latter by forcing them to distribute these nostrums at little or no profit to themselves, and to the detriment of their own business, and crowding all legitimate pharmacy to the walls.—*Detroit Times.*

DR. JOHN B. ROBERTS advocates Egyptian loofah as a clean article with which to scrub the skin before an operation. They are cheap, and can be cut into ten or twelve pieces, each one large enough for use, the cost thus being cheap enough to allow one to throw the piece away after having once made use of it.

It looks very much as if the latest divorce scandal in English high life were simply the result of a union between an exacting and hysterical young woman and a weak-eyed and weak-headed young earl. It is hardly likely that so seemingly harmless a young man could be guilty of a moiety of the enormities charged to him, but a hysterical woman will stop at nothing to gain her point. We should not be surprised to see as additional evidence on the part of Lady Constance Russell that her noble lord killed his grandmother, roasted and ate her heart.

HOW WOULD YOU LIKE THIS?—When a rich man calls in a physician he does not expect that he will be presented a bill for medical services. In fact, no such thing as a doctor's bill is known in Japan, although nearly all the other modern practices are in vogue there. The doctor never asks for his fee. The strict honesty of the people does not make this necessary. When he is through with a patient, a present is made to him of whatever sum the patient or his friends may deem to be just compensation. The doctor is supposed to smile, take the fee, bow and thank his patron.—*Canadian Druggist.*

THE subject of the removal of garbage is receiving a good portion of discussion. Don't remove it, any portion of it, so the smell of its decay will come back. It is a big undertaking for a big city to remove its garbage in such a way that it will give no offense. Dumping it in a water-course, on a lake or sea, is not getting rid of it to all purposes. In the first case it will wash down and become a pest about another town. In the second or third it will wash back to shore and breed a pestilence there. The surer way to handle garbage is to destroy it. It can then hurt no one, as it has no existence. Piled up in almost any place, it will find some way in giving off the evils of its decay to the injury of some one. Destroyed, placed out of existence, it is gone and there is nothing left. No one will be offended by it, and no means are left whereby it can come into the home or whereabouts of the people. It may not be the best way to serve garbage, but it is a safe way, and at the present time we know of no other that will prove any better.

—*Sanitary News*

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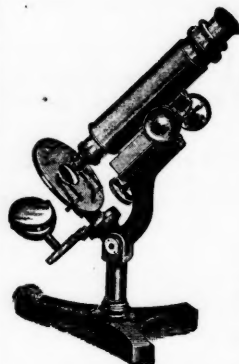
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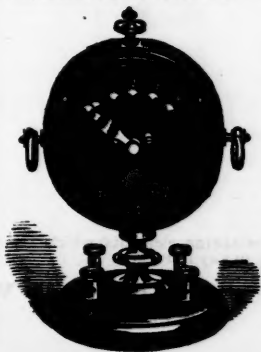
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